

15176

CERTIFICATE OF DEATH

15179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
c. LENGTH OF STAY IN 1b 1 day		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital	
d. STREET ADDRESS 93 Liberty Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HATTIE Middle E. Last ALDRIDGE		4. DATE OF DEATH Month November Day 9 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep. 11, 1911
9. AGE (In years last birthday) yrs. 56		10. IF UNDER 1 YEAR Months 5 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Aldridge		14. MOTHER'S MAIDEN NAME Carrie M. Phillips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 213-05-1633	
17. INFORMANT Miss Mildred Aldridge		Address Same As Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X DUE TO Subarachnoid hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 26 hours DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/8 , 19 67 , to 11/9 , 19 67 , that (I) (we) last saw the deceased alive on 11/9 , 19 67 , and that death occurred at 6:30 A.M. from causes on and on the date stated above.			
22a. SIGNATURE John S. Harshey		22b. DATE SIGNED 11/9/67	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS 8444 St. Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/13/1967	23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens	23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.
24. FUNERAL DIRECTOR C. M. Waltz		25a. REC'D BY REGISTRAR NOV 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Box 241 Sykesville, Md.	

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

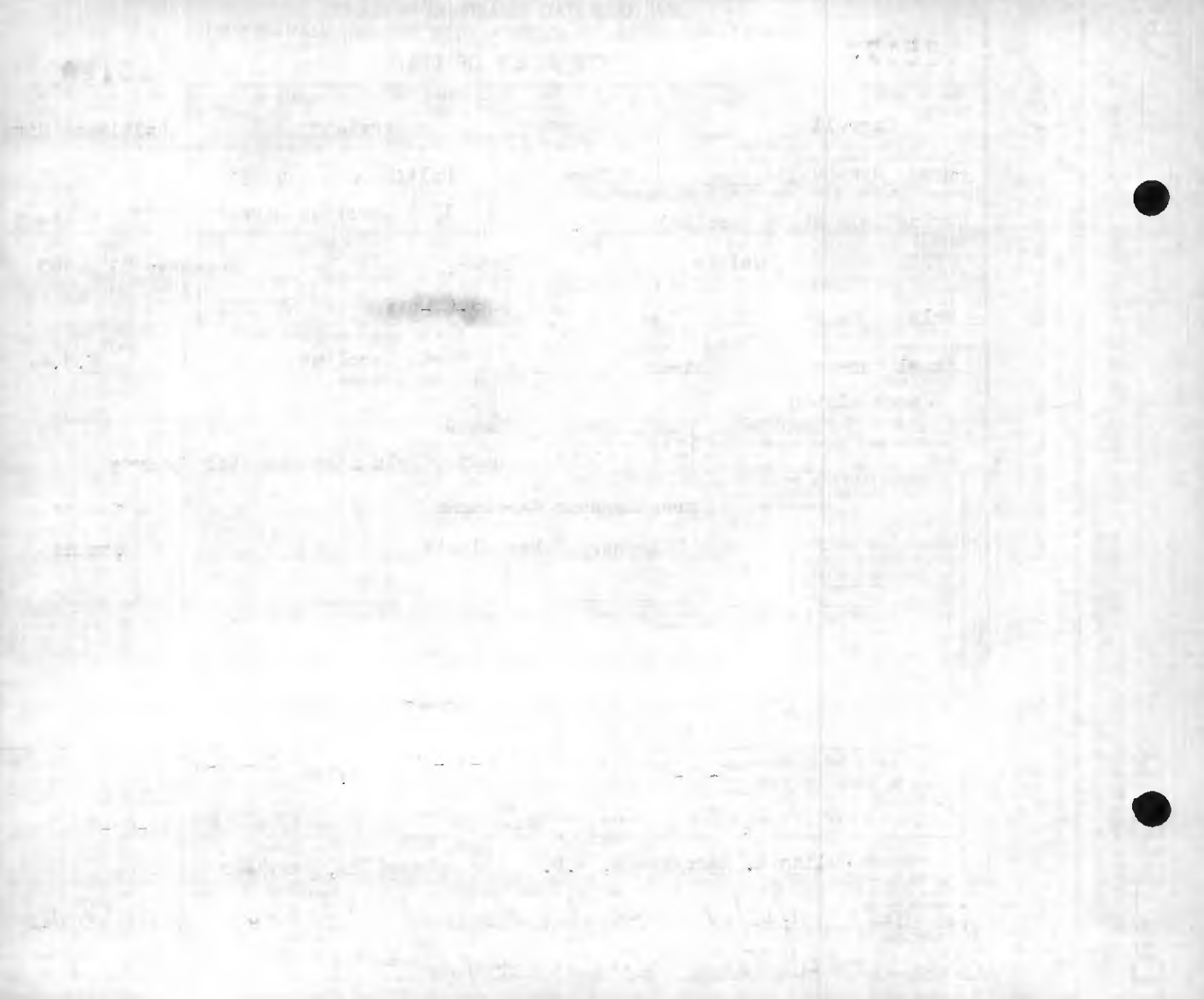
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville		c. LENGTH OF STAY IN 16 8 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1721 Caroline Street	
3. NAME OF DECEASED (Type or print) Calvin Alston		4. DATE OF DEATH Month November Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-1903
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Alston		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-3155	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. (b) Pulmonary Tuberculosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Months Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0021		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-15-67 , 19 to 11-23-67 , 19, that (I) (we) last saw the deceased alive on 11-23-67 , 19, and that death occurred at 7:10 AM , from causes on and on the date stated above.			
22a. SIGNATURE Julian R. Radzykewicz		22b. DATE SIGNED 11-23-67	
22c. PHYSICIAN'S NAME (Type) Julian R. Radzykewicz, M.D.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/26/67	23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial	23d. LOCATION (City or Town) (County) (State) Arbutus Balto. Co., Md
24. FUNERAL DIRECTOR Marshall W. Jones Jr - 1735-37		25a. REC'D BY REGISTRAR NOV 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

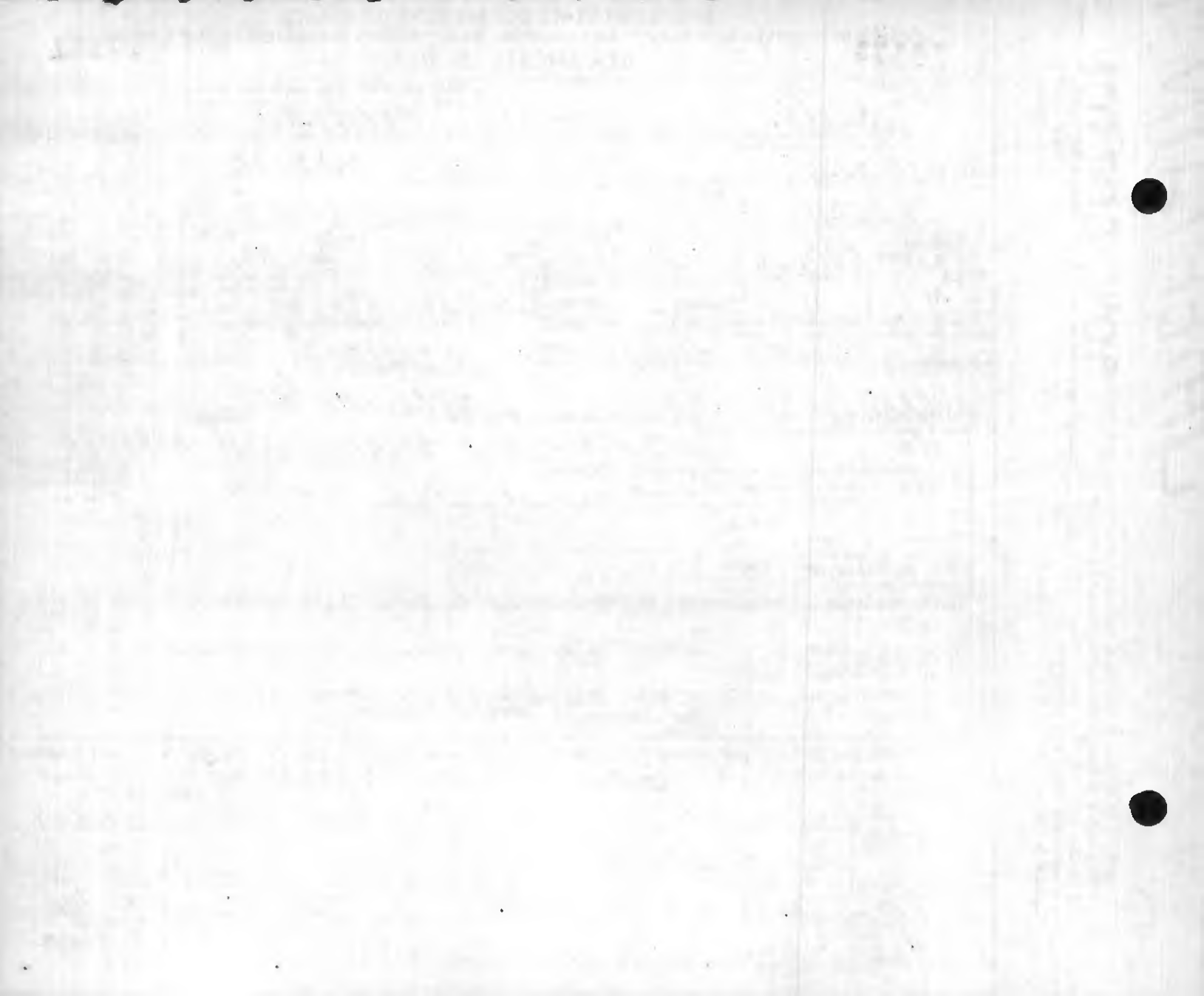


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (1)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 15178 10181 CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CHURCH ST</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> 06-1 d. STREET ADDRESS <u>CHURCH ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>CHARLES FREDERICK BACHMAN</u> First Middle Last			4. DATE OF DEATH <u>NOV 13</u> 19 <u>67</u> Month Day Year						
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 28 - 1896</u>		9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER & OPERATOR</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HARDWARE STORE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>DAVID BACHMAN</u>			14. MOTHER'S MAIDEN NAME <u>MARY LAWYER</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>213-10-9238</u>		17. INFORMANT <u>CORA BACHMAN</u> Address <u>NEW WINDSOR</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic CVD</u> 4321 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>years</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3/22/56</u> 19____, to <u>11/13/67</u> 19____, that (I) last saw the deceased alive on <u>11/13/67</u> 19____, and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>M.E. Robertson</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/14/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>ME ROBERTSON</u>			22d. ADDRESS _____						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>NOV 16 - 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>		23d. LOCATION (City, town or county) (State) <u>TANEY TOWN MD</u>		
24. FUNERAL DIRECTOR <u>DD Hartzler & Sons New Windsor Md</u>			ADDRESS _____		25a. REC'D BY REGISTRAR <u>NOV 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15179

15182

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN lb 8mo. 15days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Mac Last Bagley		4. DATE OF DEATH Month 11 Day 17 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/85
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Juston P. McLaughlin		14. MOTHER'S MAIDEN NAME Elizabeth Pinkerton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-46-9665	
17. INFORMANT Springfield Hospital records, Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary thrombosis DUE TO Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —		INTERVAL BETWEEN ONSET AND DEATH min. days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease with behavioral reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/2/1967 to 11/17/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/17/1967 , and that death occurred at 9:15 a.m. from causes and on the date stated above.			
22a. SIGNATURE Ednee J. Reeves		22b. DATE SIGNED 11/17/67	
22c. PHYSICIAN'S NAME (Type) Ednee J. Reeves, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/20/67.	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR NOV 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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REVENUE

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15180

15183

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg				c. LENGTH OF STAY IN 1b ?			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 140				d. STREET ADDRESS R.D. 1			
3. NAME OF DECEASED (Type or print) WALTER L BARNES				4. DATE OF DEATH Month 11 Day 4 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan. 20, 1920	
9. AGE (In years last birthday) yrs. 47		IF UNDER 1 YEAR Months 11 Days 4		IF UNDER 24 HRS Hours 19 Min. 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well-Driller				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Walter G. Barnes			
14. MOTHER'S MAIDEN NAME Mabel E. Barnes				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W. 2			
16. SOCIAL SECURITY NO. 218-14-2605				17. INFORMANT Mrs. Margaret A. Edmondson Address Finksburg, Md. Rt. 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured Skull, Multiple Fractures Skull DUE TO (b) & Internal Injuries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by auto.			
20c. TIME OF INJURY Month, Day, Year 8:00 p.m. 11-4 1967				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 140	
20f. (City or town) Finksburg (County) Carroll (State) Md.							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquest <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Glenn Speicher				22. DATE SIGNED 11-4-67			
EXAMINER'S NAME (Type) W. Glenn Speicher				DEPUTY MEDICAL EXAMINER 1955 E. Main St. Westminster, Carroll Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/7/1967		23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		23d. LOCATION (City or town) (County) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.				25a. REC'D BY REGISTRAR NOV 7 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

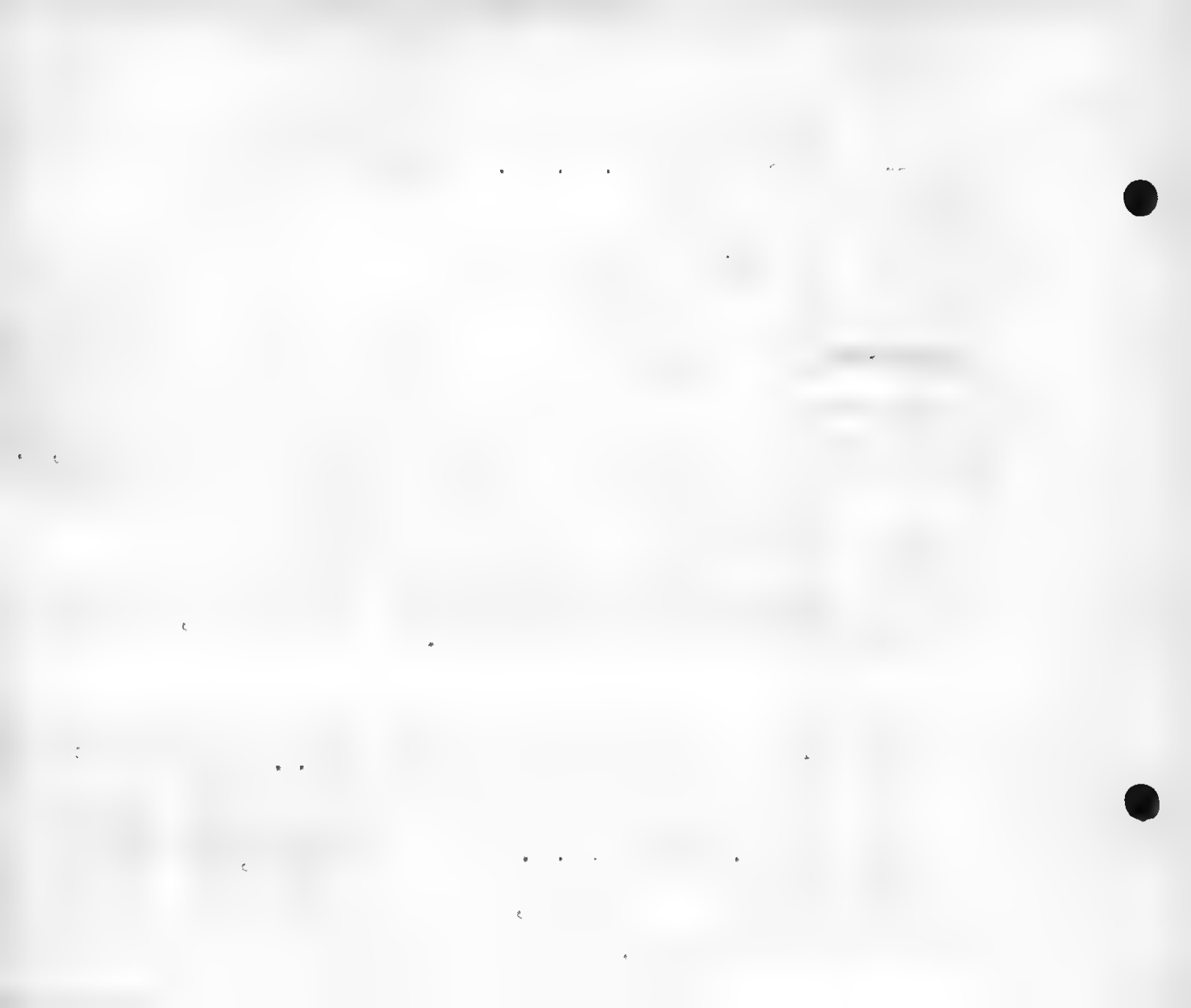
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN lb 16y. 8m. 23d.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 5207 Pembroke Avenue	
3 NAME OF DECEASED (Type or print) First Alice Middle Everette Last Bauer		4 DATE OF DEATH Month 11 Day 24 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/04
9 AGE (n years last birthday) yrs 63		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of work on 10a even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept Store	
11 BIRTHPLACE (County & State, or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Albert Sears		14. MOTHER'S MAIDEN NAME Alice Barnes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17 INFORMANT Springfield Hospital records, Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 4201			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with diseases of unknown cause, Multiple Sclerosis, with psychotic reaction.			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/1/ , 19 51 to 11/24/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/24/ 19 67 , and that death occurred at 5:45 a.m. on the date stated above.			
22a SIGNATURE Naci N. Buyukunsal, M.D.		22b DATE SIGNED 11/24/67	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/27/67	23c NAME OF CEMETERY OR CREMATORY Baltimore, Cemetery	23d LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR Loring Byers		25a. REC'D BY REGISTRAR NOV 27 1967	
ADDRESS 8728 Liberty Rd. Randallstown, Md		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15182

CERTIFICATE OF DEATH

25105

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Carroll	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c LENGTH OF STAY IN 1b Mt. Airy	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll County General Hospital		d STREET ADDRESS Rt. 2	
3 NAME OF DECEASED (Type or print) Patricia Ann Baugher		4 DATE OF DEATH Month 11 Day 13 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-12-67
9 AGE (in years last birthday) yrs		10 IF UNDER 1 YEAR Months Days	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? Md.	
13 FATHER'S NAME Douglas Wayne Baugher		14 MOTHER'S MAIDEN NAME Rosemary Theresa Schrider	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT Mother		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature 170n DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2'6 1/2" DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2'6 1/2"	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Maternal hemorrhage - marginal placenta		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-12 , 19 67 , to 11-13 , 19 67 , that (I) (we) last saw the deceased alive on 11-13 , 19 67 , and that death occurred at 4:12 M., from causes and on the date stated above			
22a SIGNATURE Karl M. Green, M.D.		22b DATE SIGNED 11/13/67	
22c PHYSICIAN'S NAME (Type) Karl M. Green, M.D.		22d ADDRESS Westminster, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) 11/13/67		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY Carroll County General		23d LOCATION (City or Town) (County) (State) Westminster, Md.	
24 FUNERAL DIRECTOR Glenn A. Fisher, Administrator		25a REC'D BY REGISTRAR NOV 20 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15183

CERTIFICATE OF DEATH

15186

1 PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Germantown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Rt. 1, Box 240	
3 NAME OF DECEASED (Type or print) First Middle Last WILLIAM HENRY BEAHM		4 DATE OF DEATH Month Day Year NOVEMBER 27 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-29-1882
9 AGE (In years last birthday) yrs 85		10 IF UNDER 1 YEAR Months Days Hours Min 11 27 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining	
11 BIRTHPLACE (County & State, or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Beahm		14. MOTHER'S MAIDEN NAME Fannie Fry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Unk.	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) Gangrene of right toe DUE TO (c) Generalized arteriosclerosis			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-5-66 , 19__, to 11-27-67 , 19__, that (I) (we) last saw the deceased alive on 11-27-67 , 19__, and that death occurred at 7:00 AM from causes and on the date stated above.			
22a. SIGNATURE <i>Octavio A. Ruiz</i>		22b. DATE SIGNED 11-27-67	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-30-67	23c. NAME OF CEMETERY OR CREMATORY Parklawn	23d. LOCATION (City or Town) (County) (State) Rockville Mont. Md.
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 29 1967	
		25b. REGISTRAR'S SIGNATURE <i>Francis H. Barber</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15184

137

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md.		c LENGTH OF STAY IN Tb 25 days.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital.		d STREET ADDRESS 49 Moore Drive	
3 NAME OF DECEASED (Type or print) First Jasper Middle Gilmore Last Bell		4 DATE OF DEATH Month 11 Day 25 Year 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 1, 1886
9 AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red) Retired Carpenter		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County, state, or foreign country) Maryland		12 CIT ZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Dave, Bell		14. MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 220-38-1425	
17 INFORMANT Hospital Records		Address Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO CORONARY ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above			
22a SIGNATURE <i>Robert L. Swartz</i>		22b DATE SIGNED 11-25-67	
22c PHYSICIAN'S NAME (Type) MD		22d ADDRESS ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 11/29/67	23c NAME OF CEMETERY OR CREMATORY Ash Memorial	23d LOCATION (City or town) (County) (State) SANDY Spring Montg, Md
24 FUNERAL DIRECTOR Robert L. Swartz		25a REC'D BY REGISTRAR DEC 6 1967	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5185

7:38

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u> c. LENGTH OF STAY IN b. <u>1 YEAR-7 MO</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BROCKFIELD MANOR N. H.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JESSE MARSHALL BOHN</u> First Middle Last 4. DATE OF DEATH <u>NOV. 7, 1967</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>3-22-1881</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-RETIRED</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>RICHARD BOHN</u> 14. MOTHER'S MAIDEN NAME <u>JENNIE SAYLOR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>215-269192</u> 17. INFORMANT <u>WM. R. ERB, JR.</u> Address <u>UNION BRIDGE, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Atherosclerosis</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>8 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>65</u> , to <u>Nov. 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/6/67</u> , 19 <u>67</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above.		22. SIGNATURE <u>Dr. A. Caricofe</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>A. CARICOFE</u> 22d. ADDRESS <u>UNION BRIDGE, MARYLAND</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>11-10-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM CEM.</u> 23d. LOCATION (City, town or county) (State) <u>FREDERICK COUNTY MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>DR. Hartzfeld</u> ADDRESS <u>UNION BRIDGE MD.</u> 25a. REC'D BY REGISTRAR <u>DATE NOV 10 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

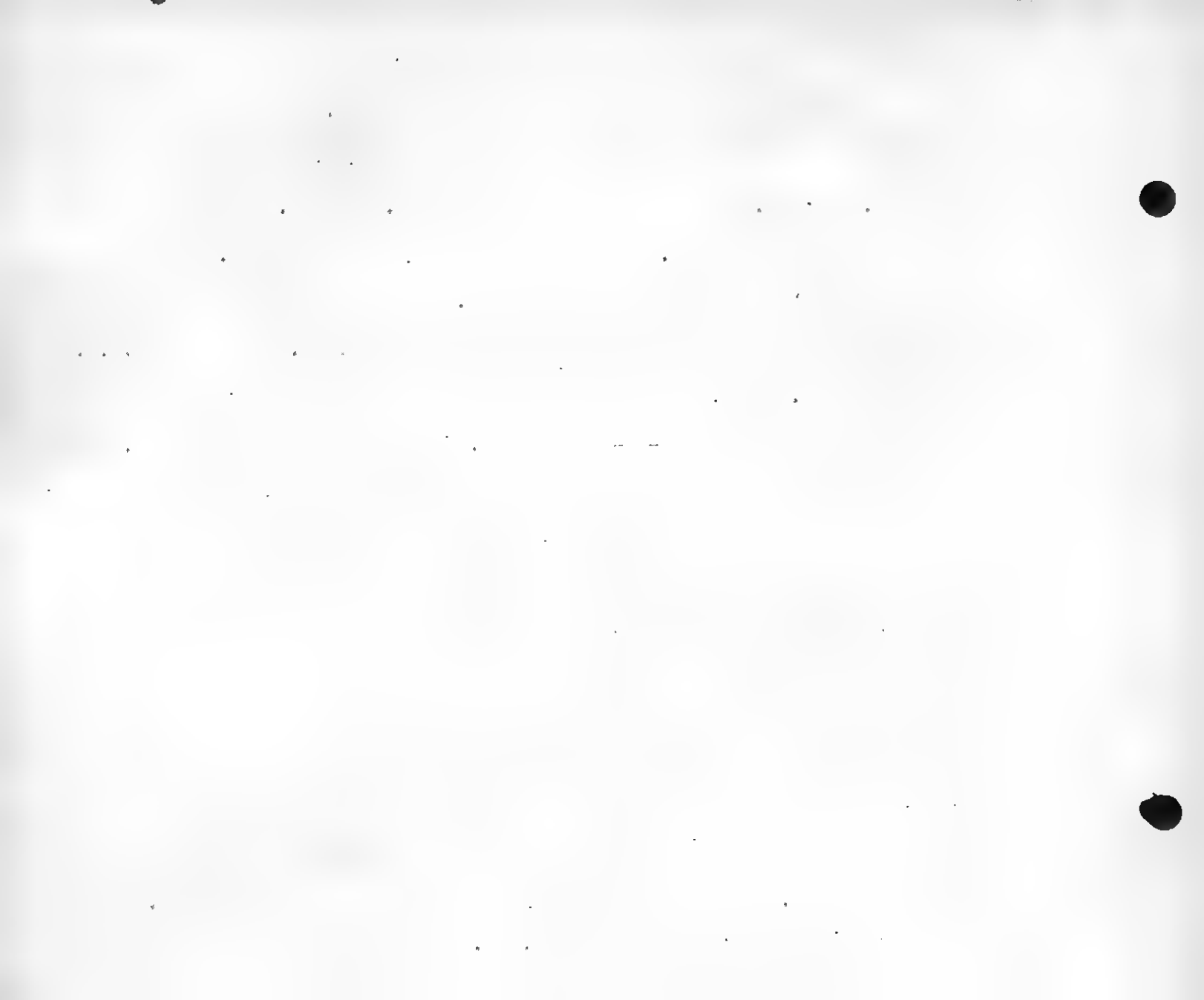
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15186 CERTIFICATE OF DEATH 1969									
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i> c. LENGTH OF STAY IN 1b <i>7 weeks</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Longview Nursing Home</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster (R.F.D.)</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Bama First Esther Middle Bowers</i>					4. DATE OF DEATH <i>Nov 7 1969</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1894 Oct 9 - 18</i>		9. AGE (In years last birthday) <i>73</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife & Housework</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Carroll County, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jonas D. Myers</i> <i>215-14-2655</i>					14. MOTHER'S MAIEN NAME <i>Selena C. Sholl</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <i>215-14-2655</i>		17. INFORMANT <i>Mrs. Gladys E. Bowers</i> Address <i>Manchester, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>no natural will cause in the chest with metastasis</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>11/2</i> , 1967 to <i>11/7</i> , 1967, that (I) (we) last saw the deceased alive on <i>11/4</i> , 1967, and that death occurred at <i>11/7</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>W. H. Ford</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11/7/69</i>		
22c. PHYSICIAN'S NAME (Type) <i>W. H. Ford M.D.</i>					22d. ADDRESS <i>Manchester, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<i>Burial</i>		<i>11/11/67</i>		<i>St. Marys Cemetery</i>		<i>Silver Run, Carroll Co., Md.</i>			
24. FUNERAL DIRECTOR <i>Richard A. Little</i>					ADDRESS <i>Littlestown, Pa.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		
							25b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 129 N. Main St.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead d. STREET ADDRESS 129 N. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Morris Middle L. Last BROOKS			4. DATE OF DEATH Month Nov. 2, Year 19 67		5. SEX Male			6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas D. Brooks					14. MOTHER'S MAIDEN NAME Zena Williams						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 212-24-5655		17. INFORMANT Mrs. Norma Brooks Hampstead, Md. 21074						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis (Liver, Brain) (b) Broncho-genic Carcinoma (c) Pulmonary Embolism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Embolism										INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs 6-7 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Aug. 16, 1967, to , 19 , that (I) (we) last saw the deceased alive on Dec. 1, 19 67, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE W C Porterfield										22b. DATE SIGNED Hampstead, Md. 21074	
22c. PHYSICIAN'S NAME (Type) Tipton - Eline Funeral Home			22d. ADDRESS Hampstead, Md. 21074		23a. BURIAL, CREMATION, BURNING (Specify) Burial			23b. DATE THEREOF Nov. 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	
23d. LOCATION (City, town or county) (State) Greenmount, Md.			24. FUNERAL DIRECTOR Tipton - Eline Funeral Home			25a. REC'D BY REGISTRAR NOV 6 1967			25b. REGISTRAR'S SIGNATURE J Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15189

15181

1 PLACE OF DEATH a COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Carroll	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c LENGTH OF STAY IN 1b 3 Weeks	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		d STREET ADDRESS 427 E. Baltimore St.	
3. NAME OF DECEASED (Type or print) First Thurman Middle Nelson Last Brown		4 DATE OF DEATH Month 11 Day 3 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 28, 1894
9 AGE (In years last birthday) yrs. 73		10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher	
10b KIND OF BUSINESS OR INDUSTRY Schools		11 BIRTHPLACE (County & State, or foreign country) Carroll County, Md.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Dennis Joshua Brown	
14. MOTHER'S MAIDEN NAME Sarah Jane Bankert		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO. 212-18-0054		17. INFORMANT Emma C. Brown, 427 E. Baltimore St., -	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA DUE TO (b) CHRONIC RENAL DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 WKS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>10/14</u>, 19<u>67</u>, to <u>11/3</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>11/3</u>, 19<u>67</u>, and that death occurred at <u>8:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <i>Richard J. Little</i>		22b. DATE SIGNED 11/3/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/6/67	
23c NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d LOCATION (City or Town) (County) (State) Silver Run, Carroll Co. Md.	
24. FUNERAL DIRECTOR Richard J. Little		25a. REC'D BY REGISTRAR NOV 6 1967	
25b. REGISTRAR'S SIGNATURE <i>John C. Judge</i>		25c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15189

CERTIFICATE OF DEATH

15182

1 PLACE OF DEATH a COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a STATE Maryland b COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster, Md. R. D. 5			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital				d. STREET ADDRESS Westminster, Md. R. D. 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Ruth Anna Buckley				4 DATE OF DEATH Month 11 Day 12 Year 1967			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/4/1890		9 AGE (In years last birthday) yrs 77	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Housework		10b. KIND OF BUSINESS OR INDUSTRY Her own home		11 BIRTHPLACE (County & State, or foreign country) Johnstown, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Geyer				14. MOTHER'S MAIDEN NAME Laura Baumgardner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-03-2903		17. INFORMANT Lewis L. Buckley, Westminster, Md. R.D.2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVA. BETWEEN ONSET AND DEATH WEEKS YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE RENAL FAILURE - TERMINAL							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/10 , 19 67 , to 11/12 , 19 67 , that (I) (we) last saw the deceased alive on 11/12 19 67 , and that death occurred at 5 P.M. from causes and on the date stated above.							
22a. SIGNATURE <i>Richard A. Little</i> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11/12/67	
22c. PHYSICIAN'S NAME (Type) Richard A. Little				22d. ADDRESS Littlestown, Pa.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/15/67		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air, Harford Co. Md.	
24. FUNERAL DIRECTOR <i>Richard A. Little</i>				ADDRESS Littlestown, Pa.		25a. REC'D BY REGISTRAR NOV 14 1967	
				25b. REGISTRAR'S SIGNATURE <i>Richard A. Little</i>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rural Sykesville, Md.</u>		c LENGTH OF STAY IN TB <u>1 YEAR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Gorsch Switch Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>FLOYD CALVIN CARR</u>		4 DATE OF DEATH <u>11 - 7 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-7-1936</u>
9 AGE (In years last birthday) <u>31</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LINEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pole Construction</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Zolan T. Carr</u>		14 MOTHER'S MAIDEN NAME <u>Daisy Norwood</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16 SOCIAL SECURITY NO <u>213-34-4107</u>	
17 INFORMANT <u>MRS. JOAN Carr</u>		Address <u>Sykesville, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for Part I and (a)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shotgun Wound upper abdomen Self Inflicted</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>abdomen Self Inflicted</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Shot Self in upper abdomen with shotgun</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-7 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) <u>Rural Sykesville Md</u> (State) <u>Md</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Glenn Speicher</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. Glenn Speicher</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-10-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>		23d. LOCATION (City or Town) <u>Sykesville Md.</u> (County) <u>Md</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u> <u>Sykesville, Md.</u>		25a. REGISTRY REGISTRAR <u>NOV 10 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 16 <u>2 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Puller Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Retta</u> First Middle Last <u>CARTER</u>		4 DATE OF DEATH <u>Nov 13</u> 19 <u>67</u> Month Day Year	
5 SEX <u>F.</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 18, 1876</u> 91 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11 BIRTHPLACE (County & State, or foreign country) <u>MD.</u>
13 FATHER'S NAME <u>John P. Phillinger</u>		14 MOTHER'S MAIDEN NAME <u>Georgia Shipley</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17 INFORMANT <u>Mrs May Harding - Wheaton, MD</u> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Wernic Coma</u> DUE TO (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>Nephrosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>10 yrs</u> <u>3 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brain Syndrome</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 17, 1964</u> , to <u>Nov 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 10, 1967</u> , and that death occurred at <u>8 A.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Sani Okutman</u> M.D.		22b DATE SIGNED <u>11.14.67</u>	
22c PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>		22d ADDRESS <u>Sykesville</u>	
23a BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u>	23b DATE THEREOF <u>11-15-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Springfield</u>	23d LOCATION (City or town) (County) (State) <u>Sykesville Carroll MD.</u>
24 FUNERAL DIRECTOR <u>Arthur H. Haight</u>		25a REC'D BY REGISTRAR <u>Sykesville, MD</u> DATE <u>NOV 16 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

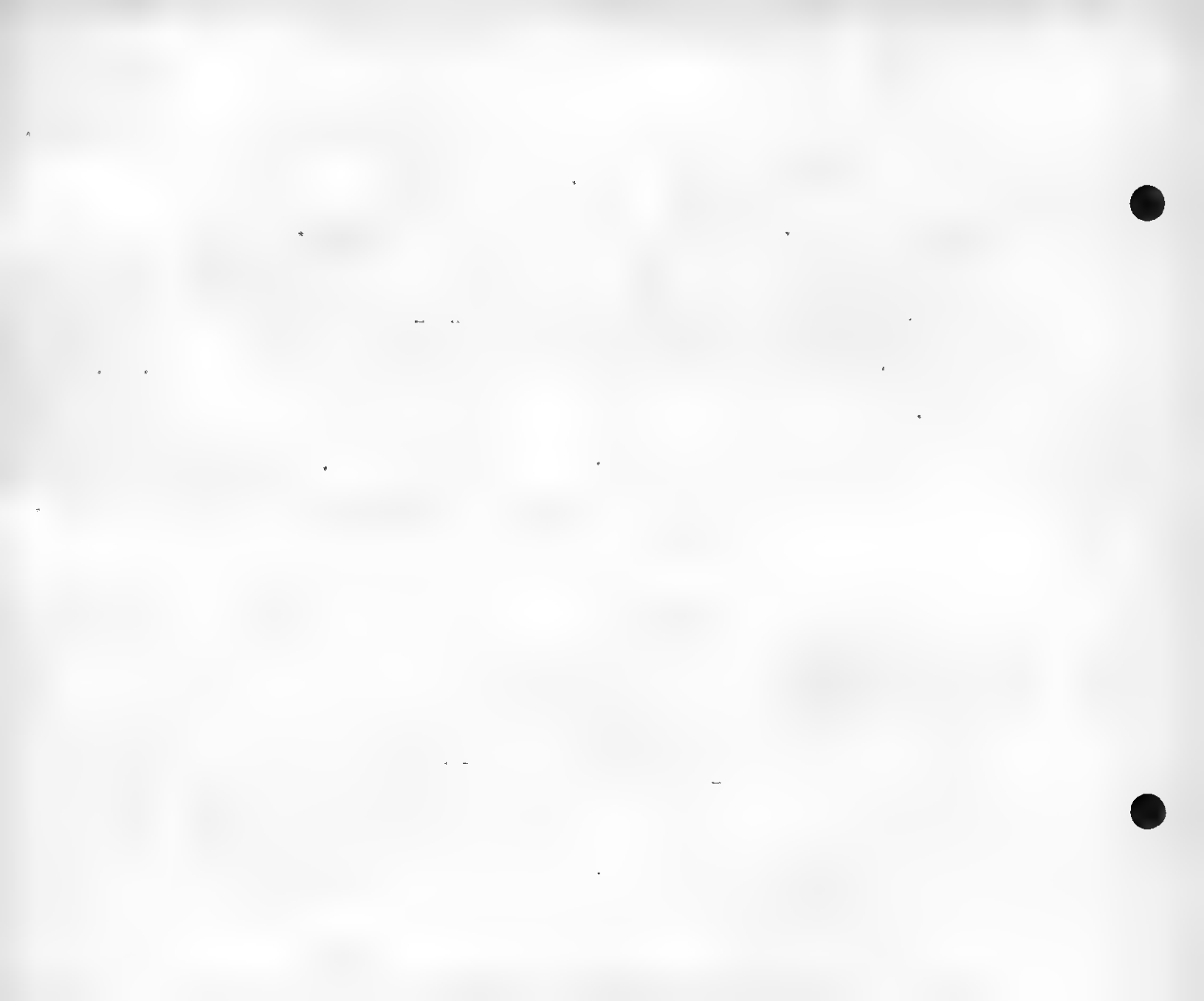
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15192

15195

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 mos. 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield St. Hospital		d. STREET ADDRESS 14 College Ave.	
3 NAME OF DECEASED (Type or print) Leona NMN Coleman		4 DATE OF DEATH November 12, 1967	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-32
9 AGE (n years last birthday) 34 yrs		F UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) South Carolina		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Irene Coleman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Unk.	
17 INFORMANT Springfield St. Hospital Records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis, active, with hemoptysis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH Many mos.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-3-67 , 19__, to 11-12-67 , 19__, that (I) (we) last saw the deceased alive on 11-12-67 , 19__, and that death occurred at 1:15 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Julian Radzykewycz</i> M.D.		22b. DATE SIGNED 11-13-67	
22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-20-67	23c. NAME OF CEMETERY OR CREMATORY Coford Med. School	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR <i>Funeral Home</i>		25a. REC'D BY REG-STRAR NOV 21 1967	25b. REG-STRAR'S SIGNATURE <i>John A. Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15193

CERTIFICATE OF DEATH

15186

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN 1b <u>3 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GEN. HOSPT.</u>				2 USUAL RESIDENCE (Where deceased lived, if inst. tct. on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FINKSBURG RD#1</u> d. STREET ADDRESS <u>LAWDALE AND BROWN ROADS</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>JOSHUA</u> First <u>NELSON</u> Middle <u>CORBIN</u> Last 4. DATE OF DEATH Month <u>NOV.</u> Day <u>16</u> Year <u>1967</u>				5 SEX <u>MALE</u> 6 COLOR OR RACE <u>WHITE</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH <u>APRIL 25, 1974</u> 9 AGE (In years last birthday) <u>93</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE OPERATOR AND CHAUFFEUR</u> 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MD.</u> 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM L. CORBIN</u> 14. MOTHER'S MAIDEN NAME <u>FLORENCE YINGLING</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16 SOCIAL SECURITY NO <u>213-50-6157</u> 17 INFORMANT Address <u>MRS. AUGUST W. HEISE FINKSBURG RD#1</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>11/13</u>, 19<u>67</u>, to <u>11/16</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>11/16</u>, 19<u>67</u>, and that death occurred at <u>10:45</u> M, from causes and on the date stated above. 22a. SIGNATURE <u>John S. Harshey</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>11/16/67</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u> 22d. ADDRESS <u>8 Anchor St. Westminster Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>11/20/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>DEER PARK CEMETERY</u> 23d. LOCATION (City or Town) (County) (State) <u>SMALLWOOD, CARROLL Co. Md.</u> 24. FUNERAL DIRECTOR ADDRESS <u>J. E. Traylor, Jr., WESTMINSTER, MD.</u> 25a. REC'D BY REGISTRAR <u>NOV 22 1967</u> 25b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician and completed and signed in by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

15194

15107

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN TB <u>9 HOURS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PHILIP EARL CRAWMER</u> First Middle Last		4. DATE OF DEATH Month <u>NOV</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 3 - 1900</u> 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM MACHINERY MECHANIC</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>PHILIP CRAWMER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH HESSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW II</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-9240</u>	
17. INFORMANT <u>MARY CRAWMER</u>		Address <u>NEW WINDSOR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____ DUE TO _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), _____ Coronary Thrombosis 9 hours		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 1b)	
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>11/19</u> to <u>11/19</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> , 19 <u>67</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u> M.D.		22b. DATE SIGNED <u>11/19/67</u>	
22c. PHYSICIAN NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>Sancho St Westminster Md</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>NOV 22 - 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WINTERS</u>		23d. LOCATION (City, town or county) <u>NEW WINDSOR MD</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>D D Hartzler & Son</u>		25a. REC'D BY REGISTRAR <u>Nov 21 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5195 5198
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN TB <u>21 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll County General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u> d. STREET ADDRESS <u>E. Baltimore Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Julia Sabina Dern</u>		4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 17, 1880</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>87</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
13. FATHER'S NAME <u>Lewis Troxell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Barton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-20-9834B</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO <u>HYPERTENSIVE ARTERIOSCLEROTIC</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) <u>CARDIOVASCULAR DISEASE</u> (c) <u>PNEUMONIA - RLL</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Mr. Clarence Dern, Taneytown, Maryland</u>		17. INFORMANT <u>Mr. Clarence Dern, Taneytown, Maryland</u> Address <u>Graceham, Fred. Co., Maryland</u> U.S.A. <u>U.S.A.</u> INTERVAL BETWEEN ONSET AND DEATH <u>21 DAYS</u> YEARS <u>0</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Taneytown, Maryland</u> (County) <u>Carroll</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/30, 1967</u> to <u>11/20, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/20, 1967</u> , and that death occurred at <u>9:23 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Vincent J. Fiocco</u> M.D.		22b. DATE SIGNED <u>11/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Vincent J. Fiocco</u>		22d. ADDRESS <u>8 Anchor St., Westminster, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/25/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grace Reformed Cemetery</u>		23d. LOCATION (City, town or county) <u>Taneytown, Maryland</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>G.O. Puss & Son</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Judge</u>		25c. ADDRESS <u>Taneytown, Maryland</u>	

CERTIFICATE OF DEATH

15199

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 4 mos.		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) White Sulphur Springs / St. Leonard	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Loring Bend e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JAMES (NMN) DOTSON		4 DATE OF DEATH Month NOVEMBER Day 10 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-11 9. AGE (in years last birthday) 56 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Dotson	
14. MOTHER'S MAIDEN NAME Jennie Grace		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Records, Springfield State Hospital Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-10-67 , 19____, to 11-10-67 , 19____, that (I) (we) saw the deceased alive on 11-10-67 , 19____, and that death occurred at 7:10 AM from causes and on the date stated above			
22a. SIGNATURE Dr. Antonius Glahn		22b. DATE SIGNED 11-10-67	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-13-67	23c. NAME OF CEMETERY OR CREMATORY Emm Baptist Church	23d. LOCATION (City or Town) (County) (State) Shenandoah Co. W. Va.
24. FUNERAL DIRECTOR Arthur H. Haight		25a. REC'D BY REGISTRAR DATE NOV 14 1967	25b. REGISTRAR'S SIGNATURE Orlando Judge



CERTIFICATE OF DEATH

15200

15197

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 20850	
c. LENGTH OF STAY IN lb 14mo 8da		d. STREET ADDRESS 803 Maple Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Elmer Downing		4. DATE OF DEATH Month Nov Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-1928
9. AGE (In years lost birthday) yrs 39		10. IF UNDER 1 YEAR Months 15 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lincoln Downing		14. MOTHER'S MAIDEN NAME Mabel Prose	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Tuberculous pneumonia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental dericiency, idiopathic, severe			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m 19 p m	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-15-66 , 19__, to 11-23-67 , 19__, that (I) (we) lost saw the deceased alive on 11-23-67 , 19__, and that death occurred at 8:45 AM , from causes on and the date stated above			
22a. SIGNATURE Julian R. Radzykewicz, M.D.		22b. DATE SIGNED 11-23-67	
22c. PHYSICIAN'S NAME (Type) Julian R. Radzykewicz, M.D.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12-1-67	23c. NAME OF CEMETERY OR CREMATORY Calvary Med. School	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Funeral Home		25a. REC'D BY REG STRA DEC 4 1967	
25b. DECEASED'S SIGNATURE Charles Judge		25c. DECEASED'S ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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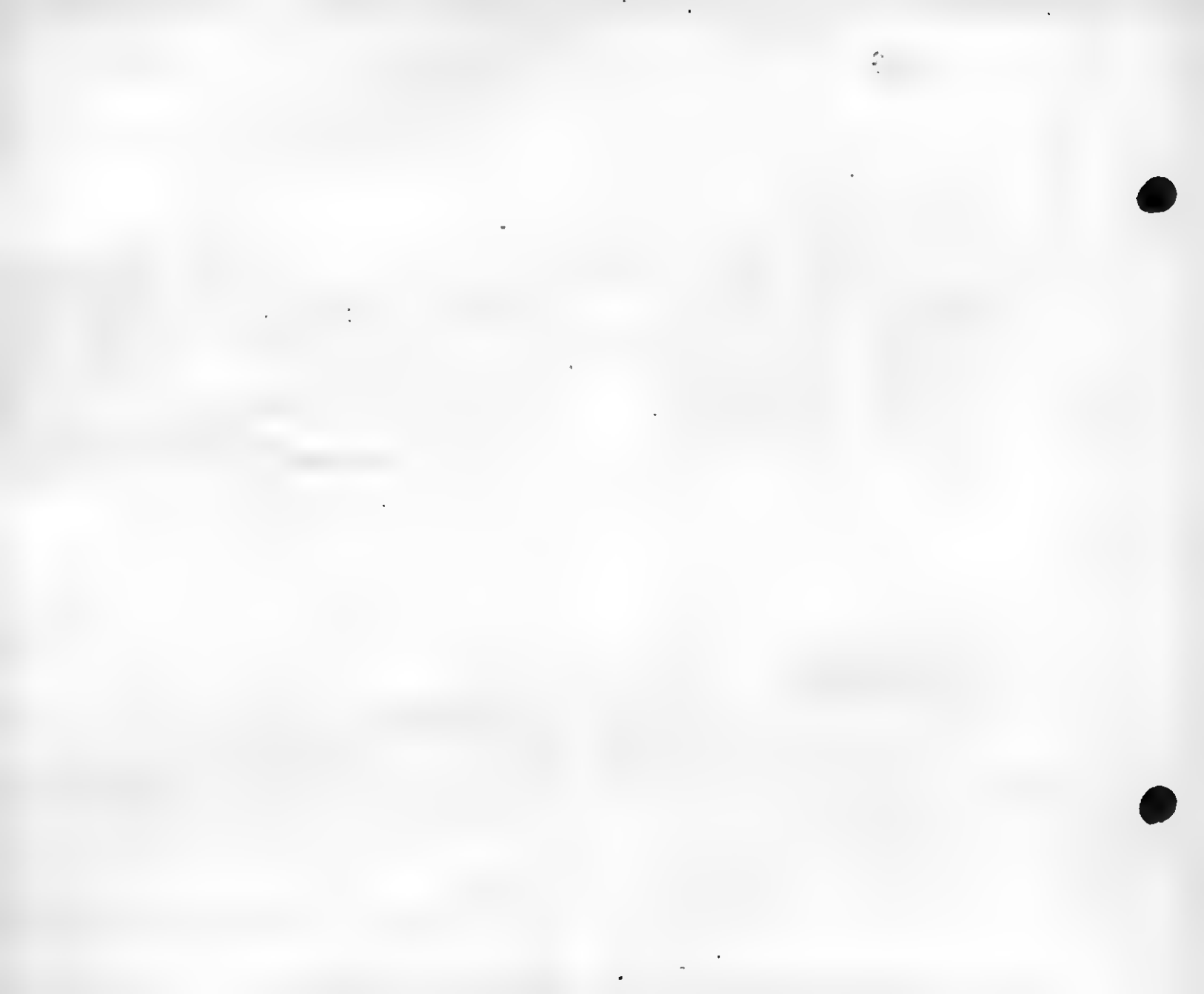
• MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15198

CERTIFICATE OF DEATH

15201

1 PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>5 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>WILMER</u> Middle <u>FLOYD</u> Last <u>DUTTERER</u>		4 DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>FEB 8, 1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN, GREENHOUSE (FLORIST)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO. MD.</u>	9. AGE (In years last birthday) <u>69</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AUSTIN D. DUTTERER</u>		14. MOTHER'S MAIDEN NAME <u>ALICE A. FEESER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>216-03-5638A</u>	
17 INFORMANT <u>STEWARD N. DUTTERER</u>		Address <u>114 PENNA AVE. WESTMINSTER, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>4301</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>YEARS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EMPHYSEMA</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 19 <u>67</u> , to <u>11/16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/16</u> , 19 <u>67</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Wm. J. Brown Jr.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b DATE SIGNED <u>11/16/67</u>
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>11/18/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER CARROLL MD</u>
24. BURIAL DIRECTOR <u>J. S. Mayo Jr., Westminster, Md</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 22 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>



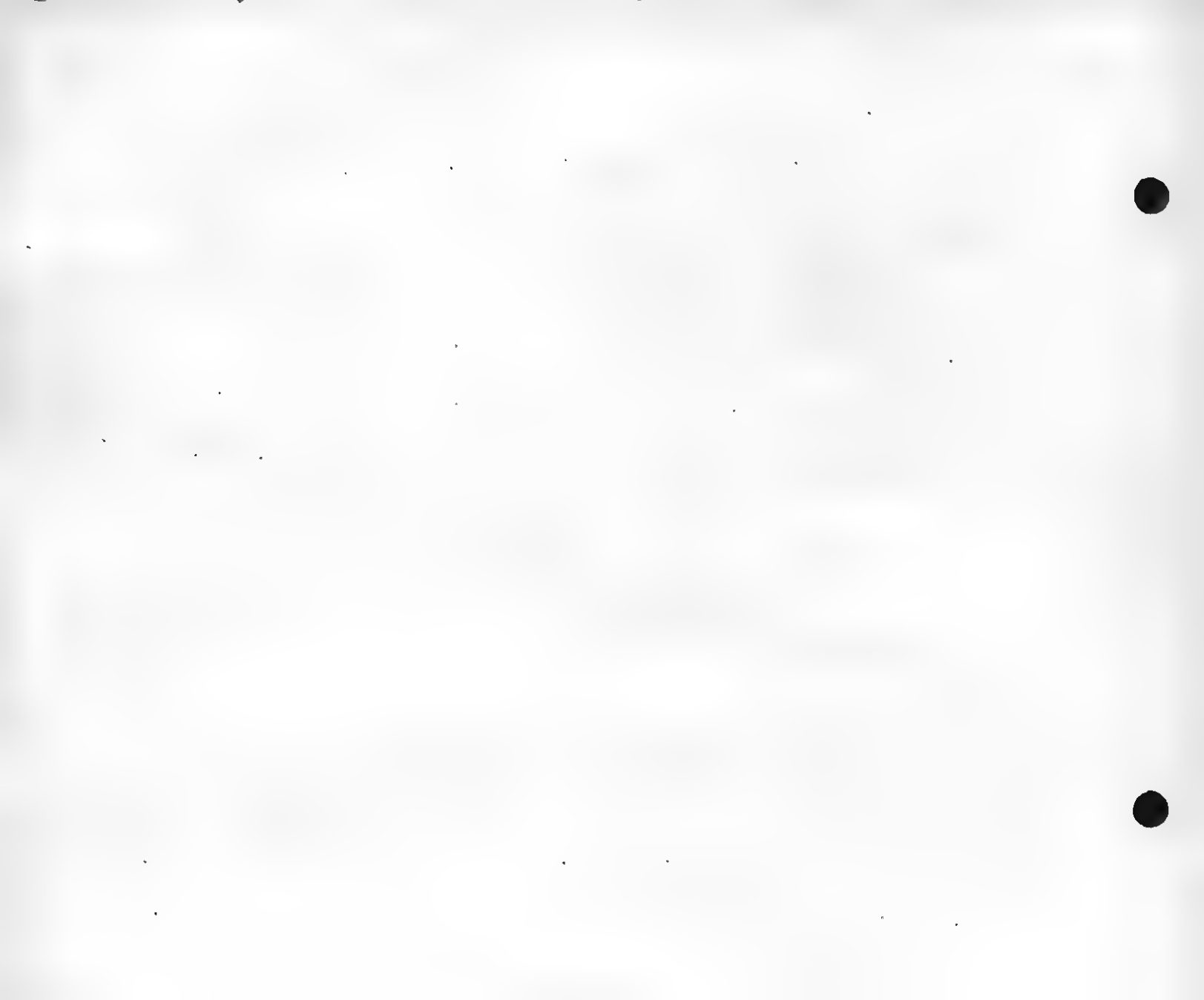
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15198
CERTIFICATE OF DEATH
15262

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>UNION BRIDGE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA ELLEN FISHER</u>				4. DATE OF DEATH Month Day Year <u>NOV 13 1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>COL</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 1 - 1893</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>LEWIS BROWN</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA (UNKNOWN)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>MD</u> <u>EVELYN DUPPINS UNION BRIDGE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V.D.</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/11/67</u> 19, to <u>11/13/67</u> 19, that (I) <u>last</u> saw the deceased alive on <u>11/13/67</u> 19, and that death occurred at <u>2:40</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>W. E. Robertson</u>				22b. DATE SIGNED <u>11/13/67</u>			
22c. PHYSICIAN'S NAME (Typed) <u>M E ROBERTSON</u>				22d. ADDRESS <u>Union Bridge, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>BURIAL</u>		<u>NOV 16 - 1967</u>		<u>KEYS CHAPEL</u>		<u>FREDERICK CO MD</u>	
24. FUNERAL DIRECTOR <u>W D Hartzler & Sons Union Bridge</u>				25a. REC'D BY REGISTRAR <u>NOV 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>W. Charles Jones</u>	

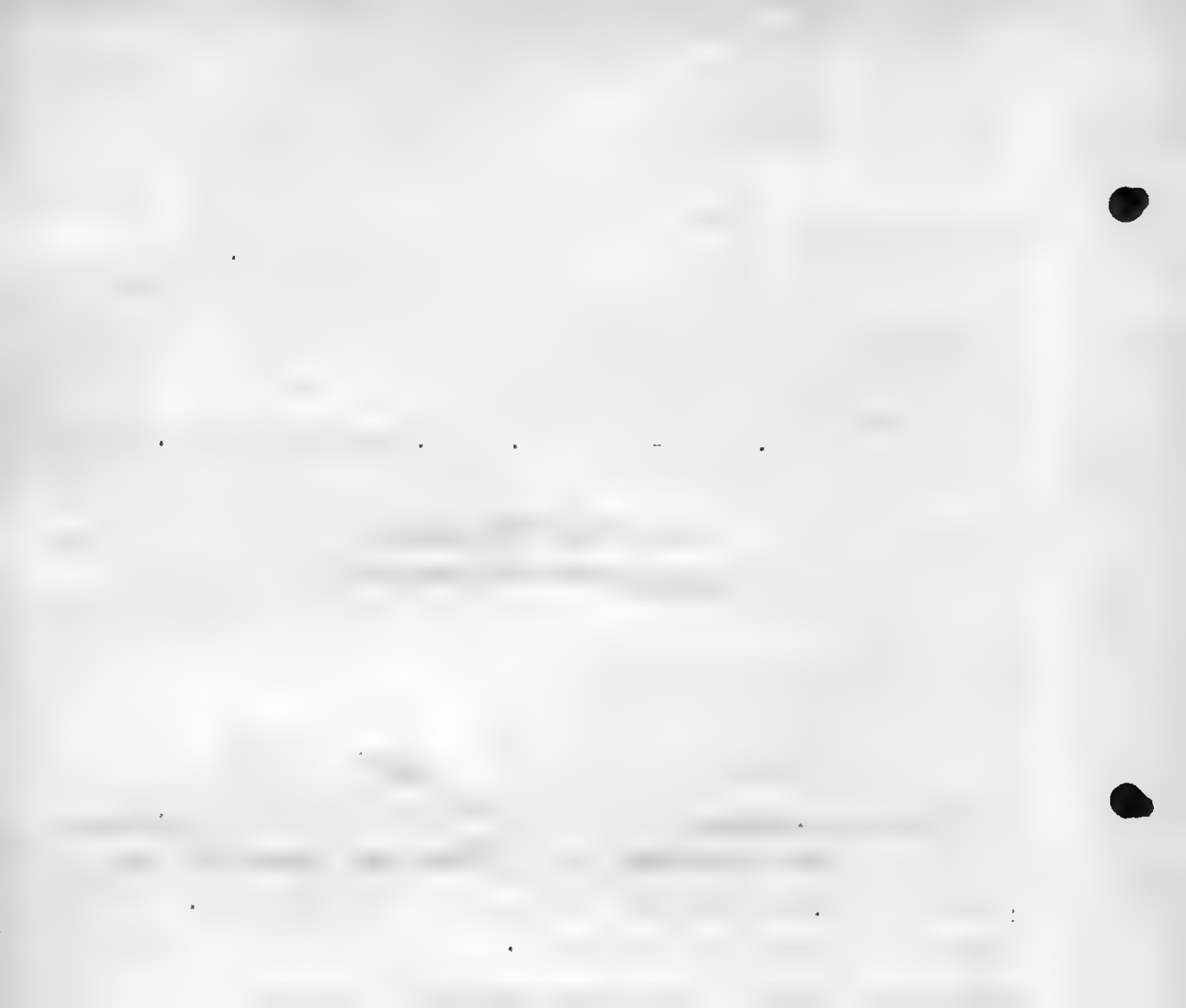


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician and completed and signed by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5200
15203
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL COUNTY HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u> d. STREET ADDRESS <u>34 N. MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EARL R. FITEZ</u>		4. DATE OF DEATH <u>Nov. 23, 19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-94</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>	
11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>215-01-6315 A</u>	
17. INFORMANT <u>Mr. John J. Fitez</u>		Address <u>1731 Cole St. Baltimore, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Atherosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> 19 <u>67</u> to <u>11/23</u> 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>11/23</u> 19 <u>67</u> , and that death occurred at <u>11/23</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>11/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Duquesne St. Westminster, Md</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 26, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Emmitsburg Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Eline Funeral Home Hampstead, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

15201

15204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Carroll</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Maryland</u>		c. LENGTH OF STAY IN lb <u>Wine days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospita, give street address) <u>Long View Nursing Home</u>			d STREET ADDRESS <u>104 New Windsor Rd</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>W. Froumfelter</u> Last <u></u>			4 DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1967</u>		
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MAY 31 1884</u>	9 AGE (in years last birthday) <u>83</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11 BIRTHPLACE (County & State, or foreign country) <u>New Windsor, Md</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13 FATHER'S NAME <u>William H Froumfelter</u>		
14 MOTHER'S MAIDEN NAME <u>Mary Myers</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO <u>215-1841294</u>			17. INFORMANT <u>Mary R Froumfelter</u> Address <u>104 New Windsor Rd New Windsor Md</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> (c) <u>Cardio Vascular Disease</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u>Emphysema</u> = <u>Cerebral Arteriosclerosis</u>					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED Where <input type="checkbox"/> Not-Where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 20</u> , 1967, to <u>Nov 29</u> , 1967, that (I) (we) last saw the deceased alive on <u>Nov 29</u> 1967 and that death occurred at <u>6:10 PM</u> , from causes and on the date stated above					
22a. SIGNATURE <u>Joseph F. Bush MD</u>		22b. DATE SIGNED <u>Nov 29 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Joseph F. Bush MD</u>	
22d. ADDRESS <u>Hampsford Mylane</u>		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2 DEC 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WINTERS CEM.</u>	
23d. LOCATION (City or Town) (County) (State) <u>Carroll County MD</u>		24. FUNERAL DIRECTOR <u>D. H. Hartzler</u> ADDRESS <u>NEW WINDSOR MD</u>			
25a. REC'D BY REGISTRAR <u>DEC 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. H. Hartzler</u>			



15202

CERTIFICATE OF DEATH

15205

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN It 15yrs. 5mos. 8days Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 228 N. Milton Avenue	
3 NAME OF DECEASED (Type or print) First ANNA Middle CRAMER Last GRAF		4 DATE OF DEATH Month November Day 2 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-1878
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (County & State, or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Graf		14. MOTHER'S MAIDEN NAME Marie Rose Cramer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-48-2498	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD with congestive heart failure DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH days years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic depressive reaction, manic type		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-24-52 , 19__, to 11-22-67 , 19__, that (I) (we) lost saw the deceased alive on 11-2-67 , 19__, and that death occurred on 11-2-67 at 9:35 am from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Antonius Glahn</i>		22b. DATE SIGNED 11-2-67	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/4/67	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR DATE NOV 3 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



15203

CERTIFICATE OF DEATH

15206

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3yrs. 8mos. 2days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 518 Oella Ave.	
3 NAME OF DECEASED (Type or print) DOROTHY AGNES GRIFFITH		4 DATE OF DEATH Month NOVEMBER Day 12 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 2-1-16 9 AGE (In years last birthday) 51 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Pierce		14. MOTHER'S MAIDEN NAME Elizabeth Kirschnick	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 213-12-3058	
17 INFORMANT Records, Springfield State Hospital		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency DUE TO (b) Far advanced pulmonary tuberculosis, quiescent DUE TO (c) Many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour : a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-10-64 , 19 to 11-12-67 , 19, that (I) (we) last saw the deceased alive on 11-12-67 , 19, and that death occurred at 3:20 PM from causes and on the date stated above			
22a SIGNATURE <i>Julian Radzykewycz</i>		22b DATE SIGNED 11-13-67	
22c PHYSICIAN'S NAME (Type) Julian Radzykewycz, M. D.		22d ADDRESS Springfield State Hospital Sykesville, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 11-15-67	23c NAME OF CEMETERY OR CREMATORY GLEN HAVEN Cem.	23d LOCATION (City or Town) (County) (State) ANNE ARUNDEL Co., Md.
24 FUNERAL DIRECTOR W. FIALKOWSKI		25a REC'D BY REGISTRAR DATE NOV 15 1967	
ADDRESS 2007 EASTERN AVE. BALTO. MD. 21231		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

2011

CERTIFICATE OF DEATH

15204

15207

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY in 1b 5 days 2 yrs. / 7 mos.		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 21211	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3420 Hickory Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Rita May HARRIS		4 DATE OF DEATH November 4, 1967	
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 7-4-95	9 AGE (In years last birthday) 72 yrs
8 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Francis Lescalleett - dec.	
14. MOTHER'S MAIDEN NAME Anna Wrenrich - dec.		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16 SOCIAL SECURITY NO.		17 INFORMANT Address Springfield State Hospital Records	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease. DUE TO (b) Generalized arteriosclerosis. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH years years.
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with cerebral arteriosclerosis with neurotic reaction.			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour: pm 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-30-65 , 19__ to 11-4-67 , 19__, that (I) (we) last saw the deceased alive on 11-4-67 , 19__, and that death occurred at 7:10 p.m. from causes and on the date stated above.			
22a SIGNATURE Dr. Antonius Glahn		22b. DATE SIGNED 11-5-67	
22c PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 11-8-67	23c NAME OF CEMETERY OR CREMATORY NATIONAL	23d LOCATION (City or Town) (County) (State) BALTO. MD.
24. FUNERAL DIRECTOR Paul E. Charney		25a. REC'D BY REGISTRAR DATE NOV 9 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15208

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN 1b 2mo. 21days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge d. STREET ADDRESS -- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Sarah First Rebecca Middle R. Last Herbert		4 DATE OF DEATH Month 11 Day 21 Year 1967	
5 SEX female	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/22/85
9. AGE (In years last birthday) 82 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Francis White	
14. MOTHER'S MAIDEN NAME Emma Virginia		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16 SOCIAL SECURITY NO 216-32-5358		17 INFORMANT Springfield Hospital records, Sykesville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Chronic brain syndrome associated with cerebral arteriosclerosis with behavioral reaction.		INTERVAL BETWEEN ONSET AND DEATH days years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis with behavioral reaction.		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/30/1967 to 11/21/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/21/1967 , and that death occurred at 10:30 a.m. from causes and on the date stated above.			
22a SIGNATURE Nael N. Buyukunsal, M.D.		22b DATE SIGNED 11/21/67	
22c PHYSICIAN'S NAME (Type) Nael N. Buyukunsal, M.D.		22d ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/24/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d LOCATION (City or Town) (County) (State) Baltimore Md.
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR NOV 24 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15206

15209

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Howard ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winfield		c LENGTH OF STAY IN 1b Dayton	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Golden Age Nursing Home		d STREET ADDRESS Ten Oaks Rd.	
3 NAME OF DECEASED (Type or print) Charles Irving Hobbs First Middle Last		4. DATE OF DEATH Nov. 3 19 67 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/1871
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wheelwright		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Hobbs		14. MOTHER'S MAIDEN NAME Emma ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 218 12 7630	
17. INFORMANT Alda Shipp Dayton Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Cerebral Thrombosis DUE TO Ch. Myocarditis DUE TO Grand Arterial Thrombosis DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 2	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr 1, 19 67 to Nov 3 19 67 That (I) (we) last saw the deceased alive on Nov 3 19 67 , and that death occurred at 11:45 PM from causes and on the date stated above.			
22a. SIGNATURE W. H. Hester M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W. H. Hester		22d. ADDRESS Hester	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 11/6/67	23c. NAME OF CEMETERY OR CREMATORY Linthicum Chaple	23d. LOCATION (City or Town) (County) (State) Clarksville Howard Md.
24. FUNERAL DIRECTOR John R. Slack		25a. REC'D BY REGISTRAR NOV 7 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Ellicott City, Md.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15207

15210

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2</u>				d. STREET ADDRESS <u>Route 2</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Howard A. Hobbs</u>				4 DATE OF DEATH Month Day Year <u>Nov. 6, 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 17, 1889</u>	
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MAINTENANCE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>William Hobbs</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Arrington</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO <u>217-07-5726</u>		17. INFORMANT <u>Mrs. Adele Hobbs - Sykesville Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Cardiac failure, acute gastric dilatation.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11/1/67 through 11/6/67</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1, 1967</u> , to <u>Nov. 6, 1967</u> that (I) (we) lost saw the deceased alive on <u>Nov. 6, 1967</u> , and that death occurred at <u>7 A.M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>Howard E. Hall</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov. 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>				22d. ADDRESS <u>Sykesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-9-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Sykesville Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Knight</u>		ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



1 *2*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15203

15211

1 PLACE OF DEATH a COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Balto. city	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN It 13 yrs lmo. 17d. c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d STREET ADDRESS 428 S. Bond St.	
3 NAME OF DECEASED (Type or print) Zebelin A. Dolphus First Adolphus Middle A. Dolphus Last Hunt		4. DATE OF DEATH Month 11 Day 26 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-28-95
10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Bricklayer & Carpenter		10b KIND OF BUSINESS OR IND. STRY Retired	9 AGE (In years last birthday) 72 yrs
11 BIRTHPLACE (County & State, or foreign country) South Carolina		2 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas Hunt		14 MOTHER'S MAIDEN NAME Ella Bornhill	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO.	
17 INFORMANT Springfield Hospital Records		Address Sykesville Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) Gangrene of Right lower leg DUE TO (c) Generalized arteriosclerosis.			INTERVAL BETWEEN ONSET AND DEATH 2 days. Days. Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Involutional Psychotic Reaction			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-26- , 19 66 , to 11-26- , 19 67 , that (I) (we) last saw the deceased alive on 11-26 19 67 , and that death occurred at 7⁰⁰ AM, from causes and on the date stated above.			
22a. SIGNATURE Suha Ozgun.		22b. DATE SIGNED 11-26-67	
22c. PHYSICIAN'S NAME (Type) SUHA OZGUN		22d. ADDRESS Springfield State Hosp Sykesville Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11-29-1967	23c NAME OF CEMETERY OR CREMATORY Oak Lawn	23d LOCATION (City or Town) (County) (State) Baltimore County, Maryland
24 FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.		25a REC'D BY REGISTRAR NOV 27 1967	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
ISM 7 62

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15208

1. PLACE OF DEATH
a. COUNTY **Carroll**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Carroll**
c. LENGTH OF STAY IN IB **1000**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **R.D.**

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE **Maryland** b. COUNTY **Carroll**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Carroll**
d. STREET ADDRESS **R.D.**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First **Edward** Middle **L.** Last **Jason**

4. DATE OF DEATH
Month **11** Day **3** Year **19 67**

5. SEX **Male** 6. COLOR OR RACE **Negro** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **April 14, 1901** 9. AGE (In years last birthday) **76** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **General** 10b. KIND OF BUSINESS OR INDUSTRY **General** 11. BIRTHPLACE (County & State, or foreign country) **Carroll, Md.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Paul J. Jason** 14. MOTHER'S MAIDEN NAME **not known**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **14-14-300** 17. INFORMANT **Dr. Charles Judge** Address **Carroll, Md.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Generalized carcinoma of prostate**
DUE TO (b) **Chronic Heart Failure**
DUE TO (c) **Arteriosclerosis**
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last, }
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **Pneumonia**
INTERVAL BETWEEN ONSET AND DEATH
6 months
1 year
10 years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ et work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **May 5, 1967** to **Nov 3, 1967** that (I) (we) last saw the deceased alive on **Oct 9, 1967**, and that death occurred at **10 PM**, from the causes and on the date stated above.

22a. SIGNATURE **Sani Okutman** M.D. 22b. DATE SIGNED **11-4-67**
22c. PHYSICIAN'S NAME (Type) **Sani Okutman, M.D.** 22d. ADDRESS **Obrecht Road, Sykesville, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **11/6/1967** 23b. DATE THEREOF **11/6/1967** 23c. NAME OF CEMETERY OR CREMATORY **Carroll Cemetery** 23d. LOCATION (City, town or county) (State) **Carroll, Md.**

24. FUNERAL DIRECTOR'S SIGNATURE **J. H. 162** ADDRESS **Carroll, Md.** 25a. REC'D BY REGISTRAR **NOV 7 1967** 25b. REGISTRAR'S SIGNATURE **Charles Judge**

CERTIFICATE OF DEATH

15213

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL SYKESVILLE</u>		c. LENGTH OF STAY IN TB <u>7 YRS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8 LYNN AVE</u>		e. STREET ADDRESS <u>8 LYNN AVE</u>	
3. NAME OF DECEASED (Type or print) <u>Richard Dudley Kunkel</u>		4. DATE OF DEATH <u>Nov. 17, 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1894</u> 9. AGE (in years last birthday) <u>73 YRS</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lead Dispatcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UTILITY CO.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John W. Kunkel</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH BAYLOR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <u>YES World War I</u>		16. SOCIAL SECURITY NO. <u>212-05-4083</u>	
17. INFORMANT <u>Mildred Kunkel</u>		Address <u>8 LYNN AVE. ROUTE 4 SYKESVILLE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO (b) <u>CONSTRICTIVE PERICARDITIS</u> DUE TO (c) <u>CHRONIC TUBERCULOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u> <u>20 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>64</u> , to <u>11-17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-17</u> , 19 <u>67</u> , and that death occurred at <u>1:30 P.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>R. V. Holck Jr.</u>		22b. DATE SIGNED <u>11-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. V. Holck Jr.</u>		22d. ADDRESS <u>SYKESVILLE, MD 21784</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>
24. FUNERAL DIRECTOR <u>Francis H. Miller</u> ADDRESS <u>2101 Frederick Ave</u>		25a. REC'D BY REGISTRAR <u>Nov 20 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

5211

15314

1 PLACE OF DEATH a COUNTY Carroll b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c LENGTH OF STAY IN 1b 2yrs.3mos.16dys. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Washington c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d STREET ADDRESS 811 Hamilton Blvd. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) CLIFFORD OWEN LAKIN		4 DATE OF DEATH Month Day Year NOVEMBER 2 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-3-12 9 AGE (In years last birthday) 55 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY ---	11 BIRTHPLACE (County & State or foreign country) Maryland 12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME Jefferson B. Lakin		14 MOTHER'S MAIDEN NAME Sally Snyder	
15 WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None	17 INFORMANT Records, Springfield State Hospital Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic fibrous pulmonary tuberculosis, DUE TO moderately advanced, active (b) Bilateral bronchopneumonia DUE TO (c) Infected decubitus ulcers Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH Years Days Weeks
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mental deficiency, idiopathic, moderate			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-16-65 , to 11-2-67 , 19__, that (I) (we) last saw the deceased alive on 11-2-67 , 19__, and that death occurred at 6:30 PM , from causes and on the date stated above.			
22a SIGNATURE <i>Julian Radzykewycz</i>		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b DATE SIGNED 11-3-67
22c PHYSICIAN'S NAME (Type) Julian Radzykewycz, M. D.		22d ADDRESS Springfield State Hospital Sykesville, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/6/67	23c NAME OF CEMETERY OR CREMATORY Rose Hill Cem Mausoleum	23d LOCATION (City or town) (County) (State) Hagerstown Wash Co Md
24 FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a REC'D BY REGISTRAR DATE NOV 8 1967	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15212

CERTIFICATE OF DEATH

15215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg MD</u>		c LENGTH OF STAY in, lb <u>7 Months</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long View Nursing Home</u>		d STREET ADDRESS <u>12 Chatham Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Charles THOMAS LARKINS</u>		4 DATE OF DEATH <u>November 17 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept 25, 1877</u>
9 AGE (in years last birthday) <u>90</u> yrs		F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Master at Quarry</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Baltimore County MD</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore County MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>William H. Larkins</u>		14 MOTHER'S MAIDEN NAME <u>Annie Frank</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>215-22-4530</u>	
17 INFORMANT <u>JAMES Larkins</u> Address <u>Nicoletta Rd Reisterstown Md</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Cardiovascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>April 1, 1967</u> , to <u>Nov 17, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 17, 1967</u> , and that death occurred at <u>6 P.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Joseph E. Bush MD</u>		22b. DATE SIGNED <u>11-17-67</u>	
22c PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		22d ADDRESS <u>Hampstead Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11/21/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Carroll Chapel Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Lutherville, Md.</u>
24 FUNERAL DIRECTOR <u>J. F. Eline & Sons</u> ADDRESS <u>Reisterstown, Md.</u>		25a REC'D BY REGISTRAR <u>Charles Jones</u> 25b REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
ISM 7-67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 608 S. Decker Ave.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pullen Nursing Home			
3. NAME OF DECEASED (Type or print) Lottie		4. DATE OF DEATH Month 11 Day 7 Year 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1894	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 11 Days 7	
11. IF UNDER 24 HRS. Hours 11 Min. 7		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Paul Olek		14. MOTHER'S MAIDEN NAME Antoinette Hoffman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-8773	
17. INFORMANT (Husband) Mr. Joseph Marski, 608 S. Decker Ave. Balto.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Coma 746A DUE TO (b) Nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Generalized Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6:25 , 19 67 to Nov 7 , 19 67 , that (I) (we) last saw the deceased alive on Oct 20 , 19 67 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Sani Okutman		22b. DATE SIGNED 11.7.67	
22c. PHYSICIAN'S NAME (Type) Sani Okutman		22d. ADDRESS Sykesville Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/10/67	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR NOV 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

15218

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eldersburg c. LENGTH OF STAY IN lb Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Md. b. COUNTY —	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Grand view Nursing Home		d. STREET ADDRESS 406 N. Loudon Ave.	
3 NAME OF DECEASED (Type or print) KATHARINE M. MEYERS		4 DATE OF DEATH Month Nov. Day 7 Year 1967	
5 SEX F	6 COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1981
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 85 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Miller		14. MOTHER'S MAIDEN NAME Margaret Himler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17. INFORMANT Bertram C. H. Meyers 616 Winans Way		Address 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.0 DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 20+ yrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ADVANCED SENILE CHANGES			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 13/Mar/66 , 19__, to 7/Nov/67 , 19__, that (I) (we) last saw the deceased alive on 6/Nov/67 , 19__, and that death occurred on 10:40 AM , from causes on and on the date stated above.			
22a. SIGNATURE Wm. H. Lawson, Jr., M.D.		22b. DATE SIGNED 7/Nov/67	
22c. PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D.		22d ADDRESS Box 54, RD #2, Sykesville, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/10/67	23c NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a REC'D BY REGISTRAR DATE	
		25b REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

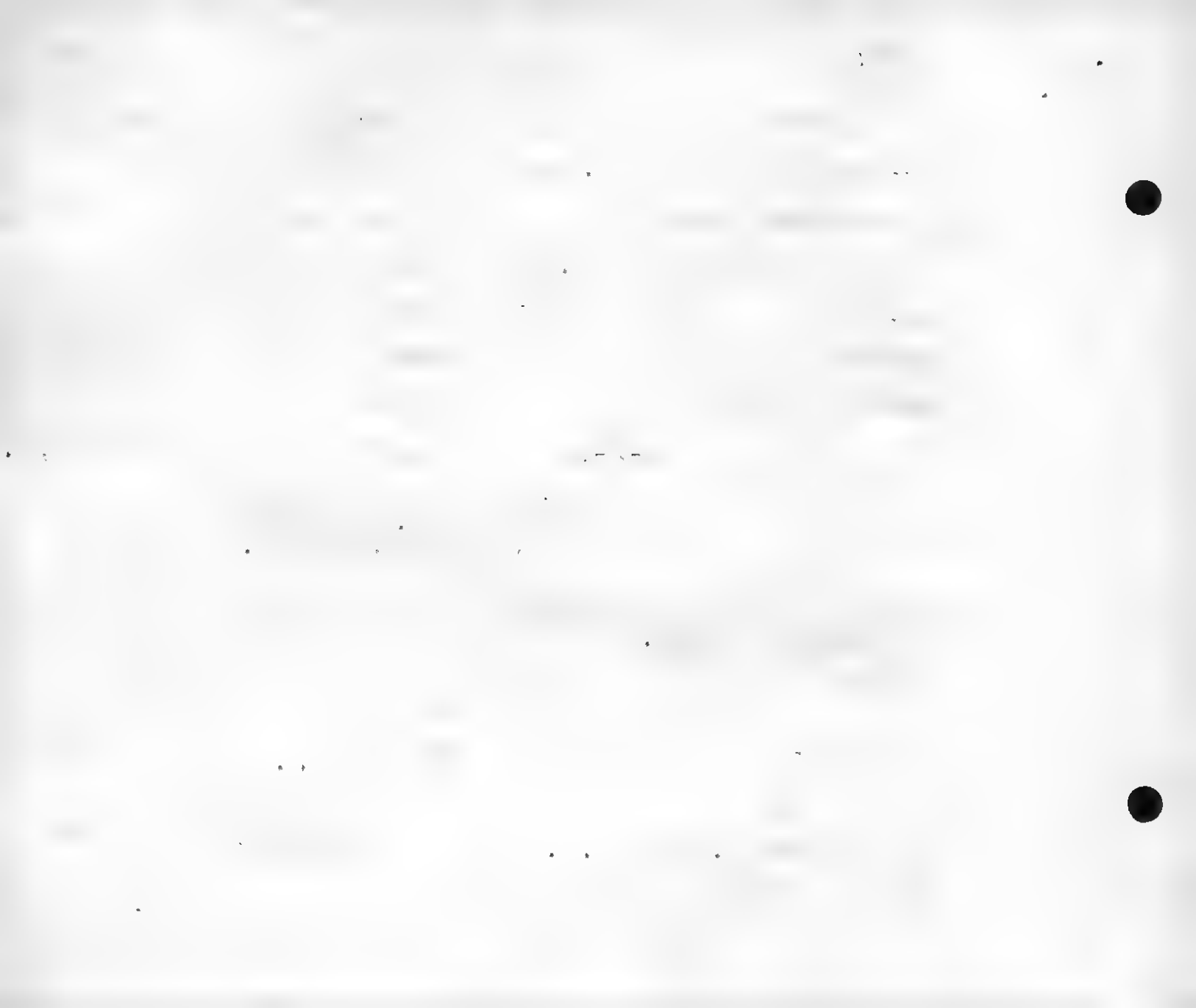
15215

CERTIFICATE OF DEATH

15219

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 3mo. 21days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 4731 Saul Road	
3. NAME OF DECEASED (Type or print) First Middle Last Marianne M. Michele		4. DATE OF DEATH Month Day Year 11 19 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/30/97
9. AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR Months Days Hours Min 11 19 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Greece
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael Trizopoulos	
14. MOTHER'S MAIDEN NAME Robinne ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 213-38-4509		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Old left ventricle myocardial infarction DUE TO coronary arteriosclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lobar pneumonia, lower lobe, left lung. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Years Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.			
19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (If this hospital) attended the deceased from 7/28/ 19 67 to 11/19/ 19 67 , that (we) last saw the deceased alive on 11/19/ 19 67 , and that death occurred at 6:35 p.m. from causes and on the date stated above.	
22a. SIGNATURE Edmee J. Reeves, M. D.		22b. DATE SIGNED 11/20/67	
22c. PHYSICIAN'S NAME (Type) Edmee J. Reeves, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/22/67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.
24. FUNERAL DIRECTOR Lydon Wheeler Rockville Md		25a. RECEIVED BY REGISTRAR DATE NOV 24 1967	
25b. REGISTRAR'S SIGNATURE Chronic Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15216

15220

1 PLACE OF DEATH a COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Carroll			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md.		c LENGTH OF STAY IN 1b 15 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d STREET ADDRESS 60 S. Colonial Ave.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Dallas Middle No Last Miller				4 DATE OF DEATH Month 11- Day 4- Year 19 67			
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-93		9. AGE (in years last birthday) yrs 73		IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b KIND OF BUSINESS OR INDUSTRY Cab Driver		11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Samuel Miller				14. MOTHER'S MAIDEN NAME Violet Caples			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 213-05-3781-B		17. INFORMANT Address Hospital Records Sykesville, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO expiration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) respiratory DUE TO respiratory (c) respiratory							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-20 , 19 67 , to 11-4 , 19 67 , that (I) (we) lost saw the deceased alive on 11-4 , 19 67 , and that death occurred at 9 A. M. from causes and on the date stated above.							
22a. SIGNATURE Mario E. Comas M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-4-67	
22c. PHYSICIAN'S NAME (Type) MARIO E. COMAS.				22d. ADDRESS Springfield State Hosp -			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/7/67		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH		23d. LOCATION (City or Town) (County) (State) WESTMINSTER RD. MD.	
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.				25a REC'D BY REGISTRAR DATE NOV 7 1967		25b REGISTRAR'S SIGNATURE J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15217

CERTIFICATE OF DEATH

15221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN Ia 12 yr. 1 mo 8 da	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ELIC (ELLYA) Middle (MELNYCZUK)		4 DATE OF DEATH Month 11 Day 20 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/18/70
9 AGE (In years lost birthday) 97 yrs		10. IF UNDER 24 HRS Months 11 Days 20 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (County & State, or foreign country) Russia		12 CITIZEN OF WHAT COUNTRY? USA Naturalized	
13 FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 220-54-7801 T	
17. INFORMANT HOSPITAL RECORDS		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gangrene of the right lower extremity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome assoc. with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from 10/13/55 , 19 67 , to 11/20/ , 19 67 that (he) (we) last saw the deceased alive on 11/20 , 19 67 , and that death occurred at 11:55M , from causes and on the date stated above.			
22a. SIGNATURE Suha Ozgun		22b. DATE SIGNED 11/20/67	
22c. PHYSICIAN'S NAME (Type) Suha Ozgun, M. D.		22d. ADDRESS Springfield State Hospital	
23a. B. RIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-24-67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Arthur H. Haight		25a. REC'D BY REGISTRAR Springfield State Hospital	
25b. REGISTRAR'S SIGNATURE Arthur H. Haight		DATE NOV 30 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Charlesville</u>		c. LENGTH OF STAY IN 1b <u>12 Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Port Charlesville</u>		d. STREET ADDRESS <u>Port Charlesville</u>	
3 NAME OF DECEASED (Type or print) First <u>Murray</u> Middle <u>Edwin</u> Last <u>Murphy</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>22</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 10, 1916</u>
9 AGE (In years last birthday) <u>51</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles W. Murphy</u>	
14. MOTHER'S MAIDEN NAME <u>Lora Lucile Porter</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>012-01-7421</u>		17 INFORMANT Name <u>Mrs. Ella V. Murphy</u> Address <u>State Ave. 10</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY INFARCTION</u> DUE TO (b) <u>CORONARY INSUFFICIENCY</u> DUE TO (c) <u>ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS.</u> <u>10 YRS.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>55</u> to <u>Nov</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-22</u> , 19 <u>67</u> , and that death occurred at <u>5:34</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. R.V. Houck, Jr.</u>		22b. DATE SIGNED <u>11-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. R.V. Houck, Jr.</u>		22d. ADDRESS <u>Liberty Rd. SYKESVILLE, MD.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carroll Co., Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>C. W. ...</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15219

15223

1 PLACE OF DEATH a COUNTY CARROLL MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Garrett			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c LENGTH OF STAY IN TB 14 yr. and 20 da		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d STREET ADDRESS 31 3rd St.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last JAMES RAYMOND MURRAY				4 DATE OF DEATH Month Day Year 11 6 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/98		9 AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b KIND OF BUSINESS OR INDUSTRY ---		11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Thomas Murray				14 MOTHER'S MAIDEN NAME Alice Virginia Meyer			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 190-10-0614		17 INFORMANT Address Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic heart disease DUE TO						INTERVAL BETWEEN ONSET AND DEATH days years years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with central nervous system syphilis, meningoencephalitic, with psychotic reaction						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/16/53 , 19 67 , to 11/6/1967 , that (I) (we) last saw the deceased alive on 11/6 1967 , and that death occurred at 4:34 PM , from causes and on the date stated above							
22a. SIGNATURE Suha Ozgun.				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 11/6/67	
22c. PHYSICIAN'S NAME (Type) Suha Ozgun, M. D.				22d. ADDRESS Springfield State Hospital			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/8/67		23c NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d LOCATION (City or town) (County) (State) Oakland Maryland	
24 FUNERAL DIRECTOR Gerald N. Minnich				ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR NOV 13 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

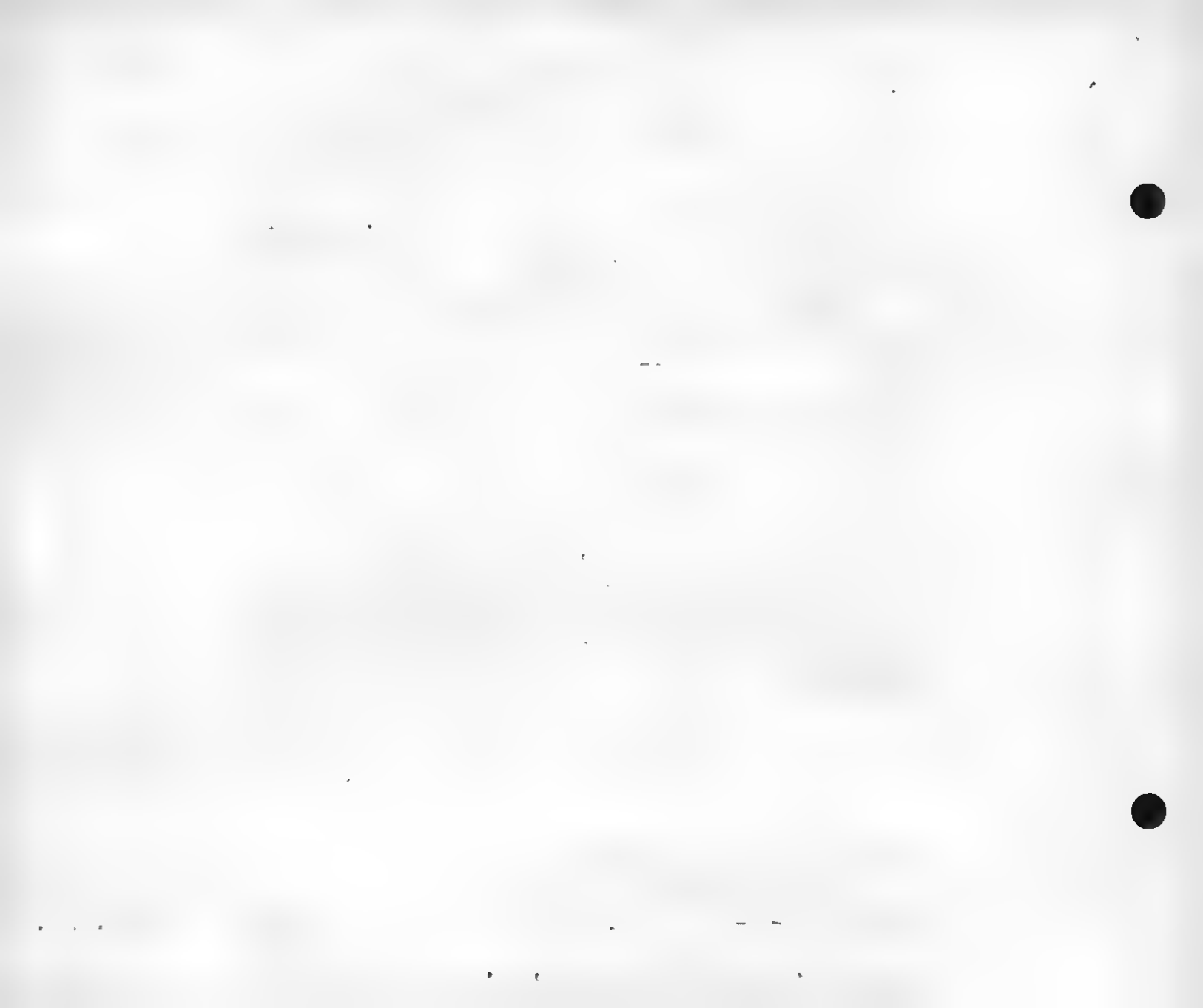
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN ID 49 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 101 WILLIS STREET		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER d. STREET ADDRESS 101 WILLIS STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY NOURSE MYERS		4. DATE OF DEATH Month Day Year NOV 15 1967	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV 21 1879	
9. AGE (in years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) ATHENS OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES M. NOURSE		14. MOTHER'S MAIDEN NAME FRANCES BLACKMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-44-2234	
17. INFORMANT JOHN E. MYERS, JR.		Address 95 WILLIS ST. WESTMINSTER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BLADDER 101- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV 15 1967 to NOV 15 1967 , that (I) (we) last saw the deceased alive on NOV 15 1967 , and that death occurred at 2:25 AM from the causes and on the date stated above.			
22a. SIGNATURE Daniel J. Welliver M.D.		22b. DATE SIGNED 11-15-67	
22c. PHYSICIAN'S NAME (Type) DANIEL J. WELLIVER, M.D.		22d. ADDRESS WESTMINSTER, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/17/67	
23c. NAME OF CEMETERY OR CREMATORY WESTMINSTER MD		23d. LOCATION (City, town or county) (State) WESTMINSTER MD	
24. FUNERAL DIRECTOR L. E. Myers, Jr.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 17 1967	



VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 10 mo 8 da	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle FRANKLIN Last NICHOLS		4. DATE OF DEATH Month 11 Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/28/89
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 78 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin Pierce Nichols		14. MOTHER'S MAIDEN NAME Sarah Ella Nichols	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 500.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Emphysema, Chronic Bronchitis DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH hrs years years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome assoc. with cerebral without qualifying phrase			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 11/8	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/30 , 19 67 , to 11/8 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/8 , 19 67 , and that death occurred at 7:15AM , from causes and on the date stated above			
22a. SIGNATURE Gracito V. Patricio M.D.		22b. DATE SIGNED 11/8/67	
22c. PHYSICIAN'S NAME (Type) GRACITO V. PATRICIO M.D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-11-67	23c. NAME OF CEMETERY OR CREMATORY Forest Oak	23d. LOCATION (City or Town) (County) (State) Gaithersburg, Mont., Md.
24. FUNERAL DIRECTOR Francis H. Barber Laytonville, Md.		25a. REC'D BY REGISTRAR NOV 10 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15226

1 PLACE OF DEATH a COUNTY CARROLL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY CARROLL	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c LENGTH OF STAY IN 1b 33 HOURS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL CO GENERAL HOSPITAL		d STREET ADDRESS CHURCH ST.	
3 NAME OF DECEASED (Type or print) CHESTER M NUSBAUM		4 DATE OF DEATH 11-15-67	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH CCT 19-1894
9 AGE (In years last birthday) 73 yrs		10 IF UNDER 1 YEAR 15 Months 15 Days 19 Hours 67 Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME MARSHALL NUSBAUM		14 MOTHER'S MAIDEN NAME JENNIE BUCKEY	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOC. A. SECURITY NO 219-20-1063	
17 INFORMANT YVONNE LAURICELLA HABERSTOWN MD		Address MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 1134 IMMEDIATE CAUSE (a) Inj. from fall from height DUE TO Crushed Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity & Diabetes		INTERVAL BETWEEN ONSET AND DEATH 33 hrs	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Tire (Front) blew out & ran off road struck		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck	
20c TIME OF INJURY Month Day Year 11-14-67		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home farm, factory, street, etc.) Route 87		20f (City or town) (County) (State) Westminster Carroll MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W Glenn Speicher MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W GLENN SPEICHER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		23b DATE THEREOF NOV 18-1967	
23c NAME OF CEMETERY OR CREMATORY TAYLORSVILLE		23d LOCATION (City or town) (County) (State) TAYLORSVILLE MD	
24 FUNERAL DIRECTOR D S Hartzler & Son		25a RECORD BY REGISTER NOV 20 1967	
Address New Windsor		25b REGISTER'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

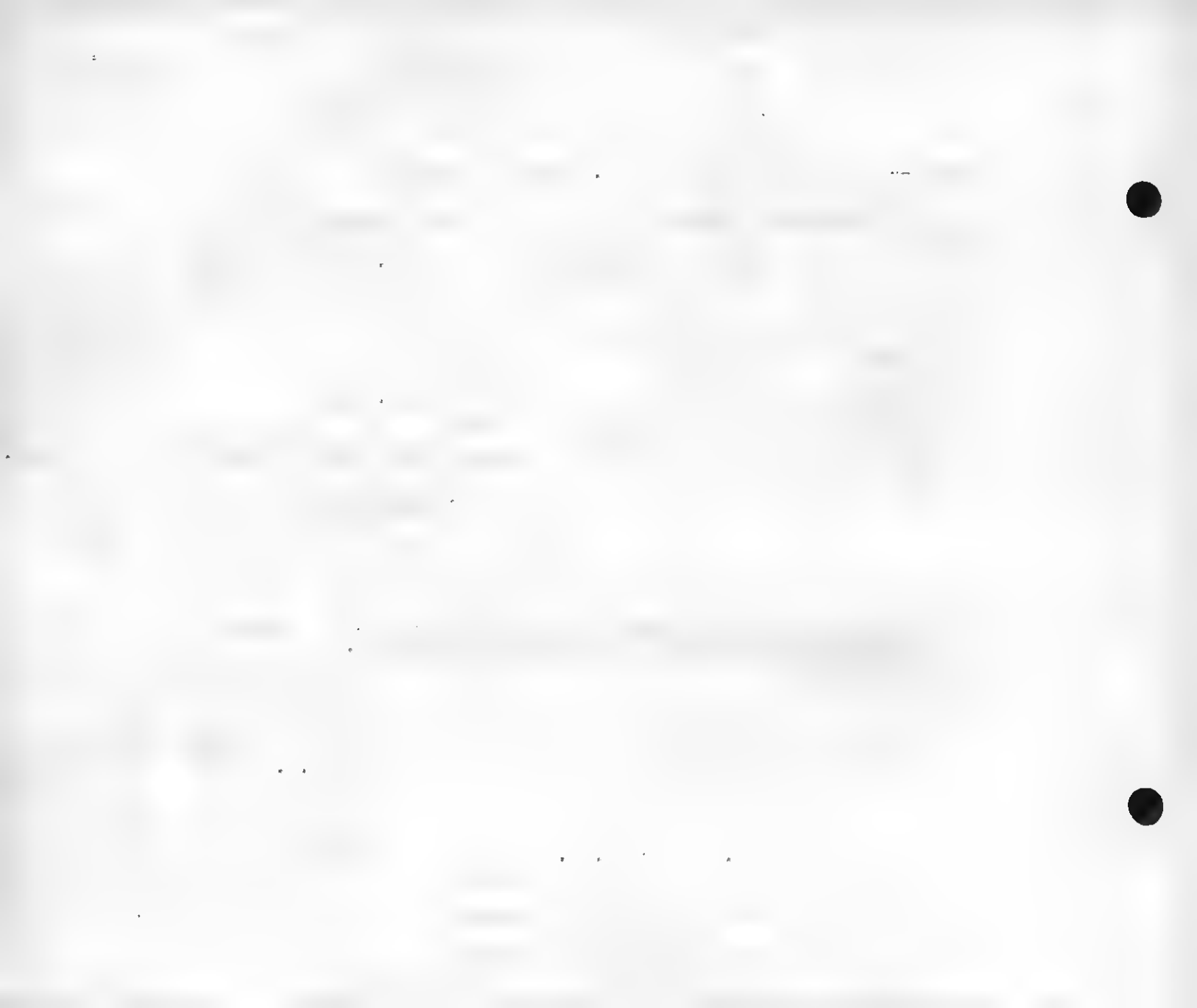
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15227

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN 1b 2mo. 15days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 9511 Edgeley Road f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Minnie Middle Amelia Last O'Connor		4 DATE OF DEATH Month 11 Day 16 Year 1967	
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/26/90 9 AGE (In years last birthday) 77 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State or foreign country) Ohio 12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME Wilhelm Knope		14. MOTHER'S MAIDEN NAME Fredericka ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. unknown	17 INFORMANT Address Springfield Hospital records, Sykesville, Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary artery embolism DUE TO 110A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Infected decubitus ulcers DUE TO (c) Pulmonary edema and congestion			INTERVAL BETWEEN ONSET AND DEATH Minutes Weeks Day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis with behavioral reaction in a paranoid personality.			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that to (this hospital) attended the deceased from 8/31/ 19 67 to 11/16/ 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/16/ 19 67 , and that death occurred at 1:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Renate R. Espina M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 11/16/67
22c. PHYSICIAN'S NAME (Type) Renate R. Espina, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/18/1967	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Rd.		25a. REC'D BY REGISTRAR DATE NOV 20 1967	25b. REGISTRAR'S SIGNATURE William J. Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

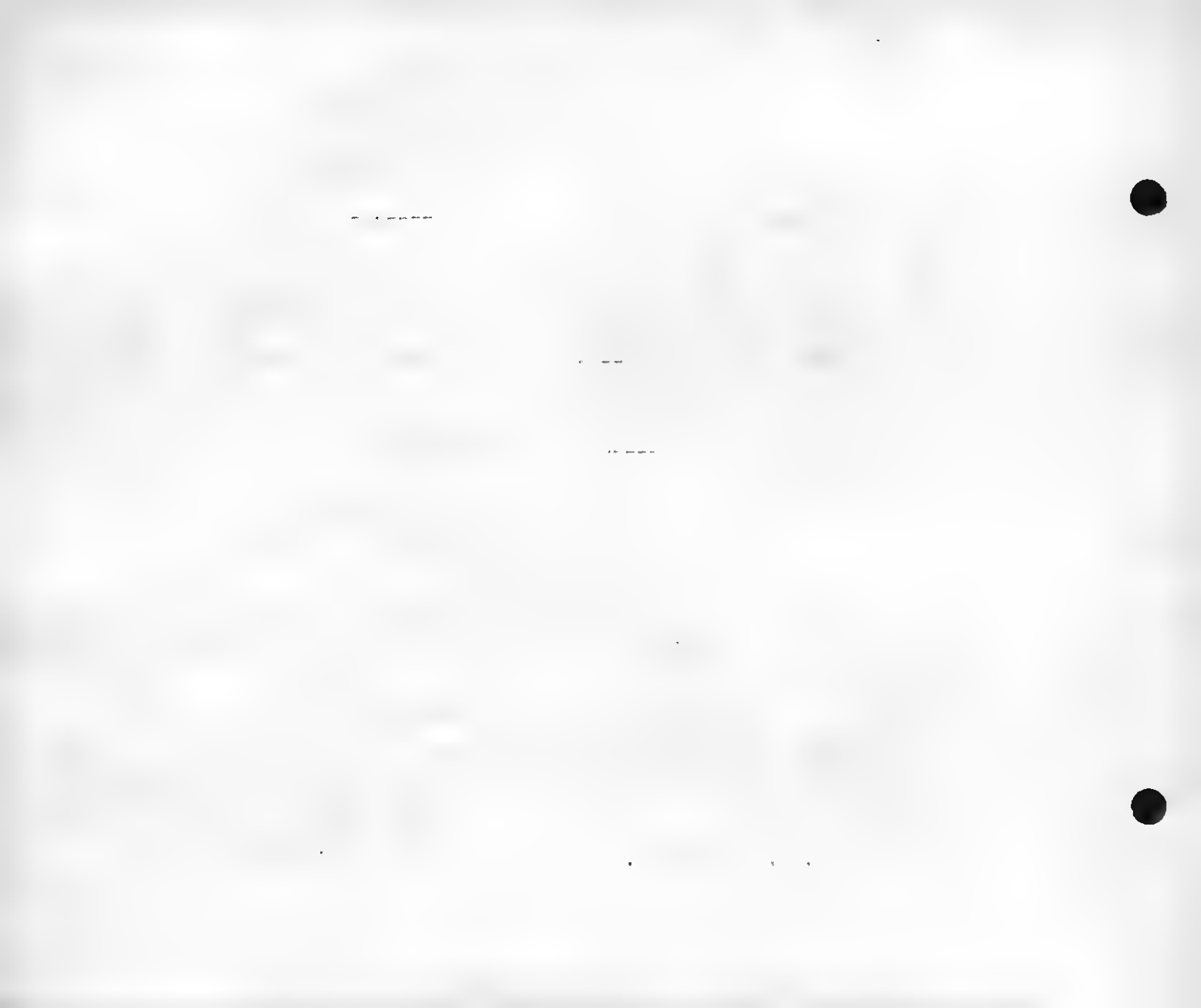
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 35 yrs 4 mo 11 da	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS Springfield State Hospital	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HERMAN RICHARD PETERS		4. DATE OF DEATH Month Day Year 11 10 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01/06/03
9. AGE (in years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (County & State, or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Peters		14. MOTHER'S MAIDEN NAME Anna Mulligan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pneumonia 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type		INTERVAL BETWEEN ONSET AND DEATH 12 Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 6/29/ , 19 32 , to 11/10 , 19 67 , that he (we) last saw the deceased alive on 11/10 , 19 67 , and that death occurred at 3:42 AM, from causes and on the date stated above.			
22a. SIGNATURE H. E. Connor, Sr.		22b. DATE SIGNED 11/10/67	
22c. PHYSICIAN'S NAME (Type) H. E. Connor, Sr., M. D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-18-67	
23c. NAME OF CEMETERY OR CREMATORY New Freedom		23d. LOCATION (City or town) (County) (State) Sykesville, Md.	
24. FUNERAL DIRECTOR Haight Funeral Home		25a. REC'D BY REGISTRAR NOV 21 1967	
ADDRESS Sykesville, Md		25b. REGISTRAR'S SIGNATURE Charles Jones	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15229

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Carroll	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster RD#7		c LENGTH OF STAY IN lb 79 yrs	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hughes Shop Road		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) HERBERT JOSEPH PETRY SR.		4 DATE OF DEATH 11 - 10 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years lost birthday) 81 yrs
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		9b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David R. Petry		14. MOTHER'S MAIDEN NAME Harriet Young	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -- --		16 SOC. SEC. SECURITY NO. 212-32-3230	
17 INFORMANT Mrs. Andrew J. Hoff		Address New Windsor, Maryland	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull & Internal Injuries DUE TO (b) Internal Injuries DUE TO (c) Internal Injuries (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last)			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) From tractor & disc harrow into 10 ft pit	
20c. TIME OF INJURY Month, Day Year 2:45 pm 11-10-1967	20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Nat White <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Noturol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 11-10-67	
ACTUAL SIGNATURE W. L. Specker M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. L. Specker		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/13/67	
23c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery		23d. LOCATION (City or town) rural Westminster, Md.	
24. FUNERAL DIRECTOR L. J. Meyer Jr. Westminster, Md.		25a. REC'D BY REGISTRAR NOV 13 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

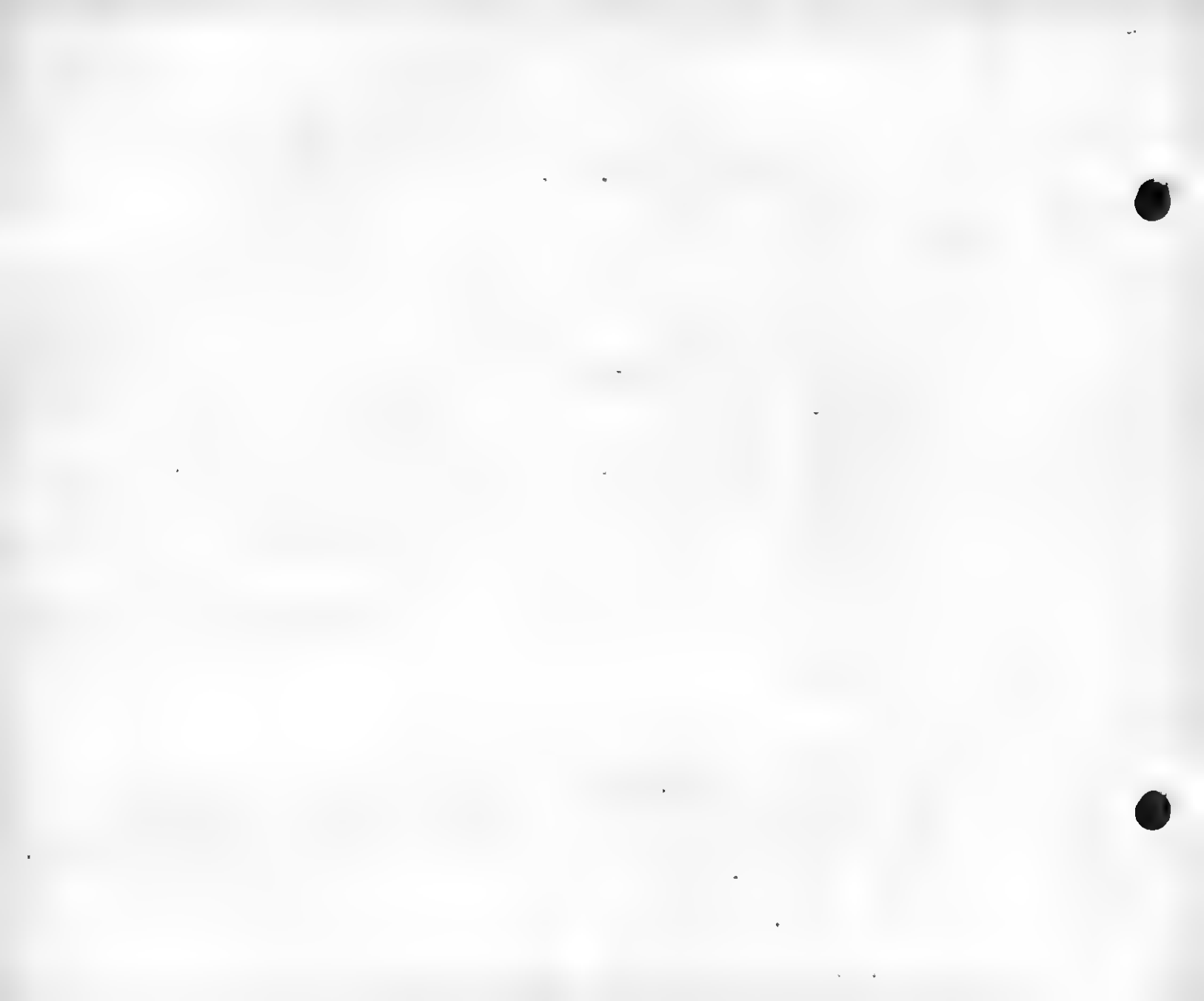


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville			c. LENGTH OF STAY IN TB 1yr. 4mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 228 E. Church			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Peter Middle Henry Last Raun					4. DATE OF DEATH Month 11 Day 24 Year 19 67				
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/89		9. AGE (In years last birthday) 78 YES	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer			10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Clinton, Iowa			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Rayh					14. MOTHER'S MAIDEN NAME Under, or Martha Saloman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 220-03-1394		17. INFORMANT Hospital Records Sykesville, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC BRAIN SYNDROME DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIO-SCLEROSIS DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from 7/24/19 66 to 11/24/19 67 that (I) (we) last saw the deceased alive on 11/24/19 67 , and that death occurred at 1:50A M , from causes and on the date stated above.									
22a. SIGNATURE Ramon P. Lopez					M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 11/24/67		
22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez					22d. ADDRESS Skysville, Md. Springfield State Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery			23d. LOCATION (City or Town) (County) (State) Frederick, Maryland		
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland					25a. REC'D BY REGISTRAR NOV 27 1967		25b. REGISTRAR'S SIGNATURE M. R. Etchison		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

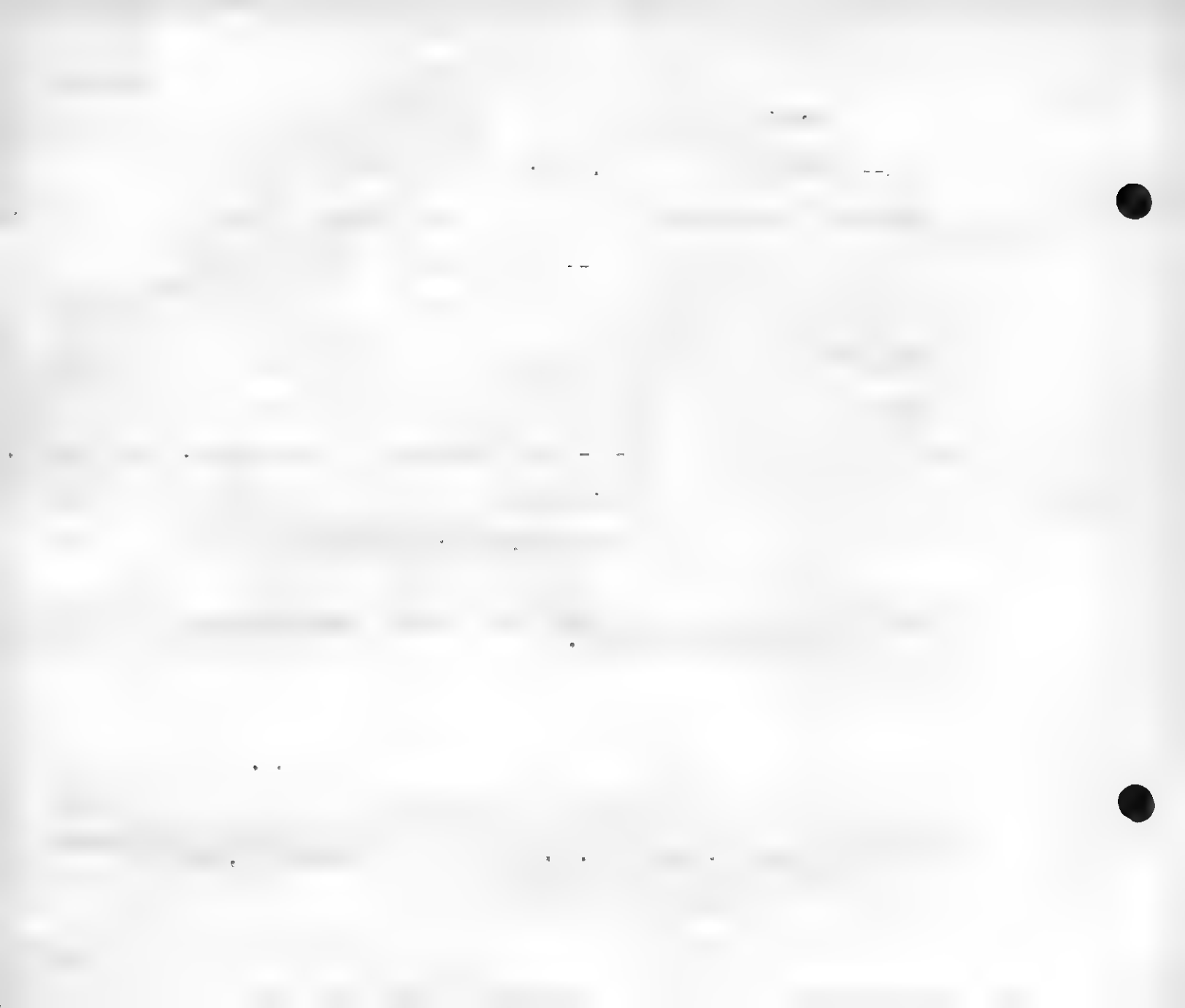
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c LENGTH OF STAY IN 1b 5mo. 20days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Corinna Middle -- G Last Reck		4 DATE OF DEATH Month 11 Day 21 Year 19 67	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/20/96
9 AGE (In years last birthday) yrs. 71		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Nova Scotia	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Robert Grant	
14 MOTHER'S MAIDEN NAME Matilda McDonald		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16 SOCIAL SECURITY NO 137-09-8813		17 INFORMANT Springfield Hospital records, Sykesville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/31/ 1967 to 11/21/ 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/21/ 1967 , and that death occurred at 5:30 p.m. from causes and on the date stated above			
22a. SIGNATURE Edmee J. Reeves		22b. DATE SIGNED 11/21/67	
22c. PHYSICIAN'S NAME (Type) Edmee J. Reeves, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV 24 1967	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM	23d. LOCATION (City or Town) (County) (State) FREDERICK BALTO MD
24 FUNERAL DIRECTOR THE DIPPEL BROS INC		25a. REC'D BY REGISTRAR NOV 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY CARROLL COUNTY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
c. LENGTH OF STAY IN 1b 4 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CARROLL COUNTY GEN. HOSP.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
d. STREET ADDRESS 55 LIBERTY STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) HERBERT EUGENE RHOTEN
4. DATE OF DEATH NOV. 2 1967
5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH SEPT 1, 1892 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M'n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR MANUFACTURING CARROLL CO. MD. 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME FRANK RHOTEN 14. MOTHER'S MAIDEN NAME KATIE MYERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO 16. SOCIAL SECURITY NO. 216-07-3806 17. INFORMANT MRS RUTH SHIMP Address 55 LIBERTY ST. WESTMINSTER MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary emphysema (b) 11 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)

21. I certify that (I) (this hospital) attended the deceased from 10/5 to 11/2, that (I) (we) last saw the deceased alive on 11/2, and that death occurred at 12:37 AM, from the causes and on the date stated above.

22a. SIGNATURE John S. Harshey M.D. 22b. DATE SIGNED 11/2/67
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY M.D. 22d. ADDRESS Bancker St. Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF NOV 4/67 23c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY 23d. LOCATION (City, town or county) (State) BETHEL, CARROLL, MD.

24. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell ADDRESS 254 E. MAIN ST. WESTMINSTER, MD. 25a. REC'D BY REGISTRAR DA NOV 3 1967 25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and attach to the certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15225
15233
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL CO.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RT#5</u>		c. LENGTH OF STAY IN 1b <u>8 YRS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WARFIELD SBURG</u>		d. STREET ADDRESS <u>WARFIELD SBURG</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GERTRUDE ROHLEDER</u>		4. DATE OF DEATH Month Day Year <u>NOV. 27 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 28 1903</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 4 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN F. ROHLEDER</u>		14. MOTHER'S MAIDEN NAME <u>SOPHIA THUMEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ROSEMARY A. ROHLEDER, WASH. D.C.</u>		Address <u>1357 CAPITOL ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Coronary disease</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>apparently only few minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1, 1967</u> to <u>Nov. 27, 1967</u> that (I) (we) last saw the deceased alive on <u>Nov. 25, 1967</u> and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>G. Reese Wilkens</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DR. F. REESE WILKENS</u>		22d. ADDRESS <u>15 Kemper Cir. Westminster Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/30/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>		23d. LOCATION (City, town or county) (State) <u>WESTMINSTER MD.</u>	
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr. Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>Nov 30 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10234

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Adams</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>Littlestown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County Gen. Hospital</u>		d. STREET ADDRESS <u>102 Cemetery Street</u>	
3 NAME OF DECEASED (Type or print) <u>JOHN FRANCIS RUTH</u>		4 DATE OF DEATH <u>11-16-67</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (in years last birthday) <u>27</u> yrs
9 BIRTH DATE <u>6-11-40</u>		10 FUND 1 YEAR <u>11</u> MONTHS <u>16</u> DAYS <u>27</u> HOURS <u>16</u> MIN	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Francis Ruth</u>		14 MOTHER'S MAIDEN NAME <u>Rose</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16 SOCIAL SECURITY NO. <u>220-36-3025</u>	
17 INFORMANT <u>Mrs. Margaret F. Ruth</u>		Address <u>102 Cemetery St., Littlestown Pa.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Skull & Multiple Fractures</u> DUE TO <u>Fractures</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Fractures</u> (b) <u>Fractures</u> (c) <u>Fractures</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>Lost Control Car & I turned over several times</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 18) <u>Lost Control Car & I turned over several times</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:50 p.m. 11-16-67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>Not at work</u>	
20e. PLACE OF INJURY (Home, farm, etc.) <u>Carroll County Md</u>		20f. (City or town) (County) (State) <u>Westminster Carroll Md</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William Specker</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William Specker</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>11-16-67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. B. R. I. A. L. R. E. M. O. V. A. L. (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/21/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cem</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore Md</u>	
24 FUNERAL DIRECTOR <u>Nicholas T. Matthews</u>		25a. REC'D BY REGISTRAR <u>Nicholas T. Matthews</u>	
ADDRESS <u>3021 Eastern Ave., Baltimore, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Nicholas T. Matthews</u>	
DATE <u>NOV 21 1967</u>		JUDGE <u>Nicholas T. Matthews</u>	

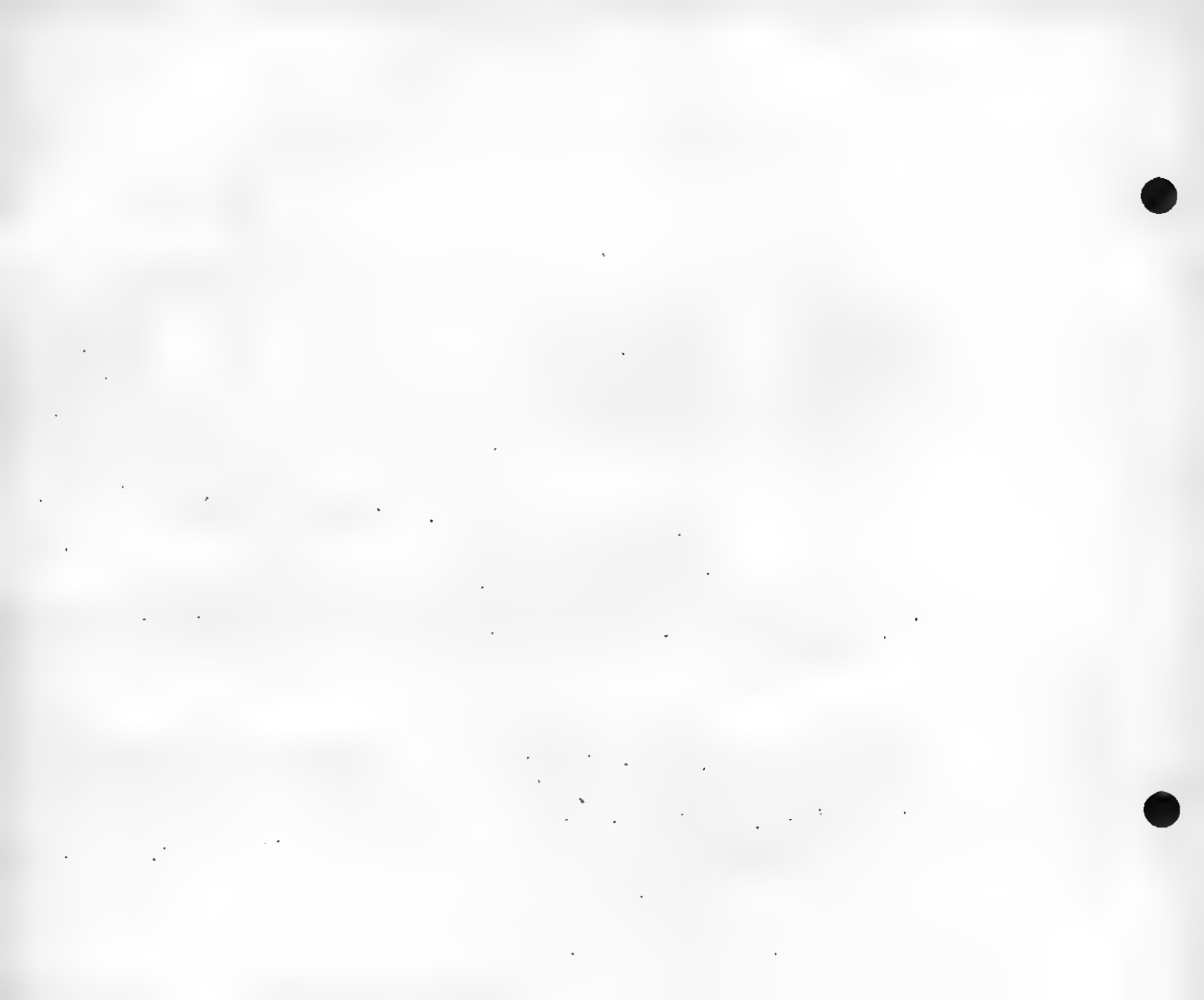


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15231											
15235											
1. PLACE OF DEATH a. COUNTY CARROLL COUNTY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - RT #6 WESTMINSTER						c. LENGTH OF STAY IN 1b 65 YRS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SMALLWOOD - RT 6 WESTMINSTER						d. STREET ADDRESS SMALLWOOD RT 6 WESTMINSTER					
3. NAME OF DECEASED (Type or print) WALTER RICHARD SAYLOR						4. DATE OF DEATH NOV 15 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 16, 1902		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR				10b. KIND OF BUSINESS OR INDUSTRY BUILDING		11. BIRTHPLACE (County & State, or foreign country) CARROLL CO. MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME WILLIAM HENRY SAYLOR						14. MOTHER'S MAIDEN NAME CATHERINE BAKER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 218-09-4229A		17. INFORMANT WIFE PAULINE H. SAYLOR				Address RT #6 Box 55 WESTMINSTER MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic Carcinoma of Lung</i> DUE TO <i>Emphysema Recurrent Hemoptysis</i> (b) <i>renal</i> DUE TO <i>pyelonephritic changes, RT Kidney</i> (c) <i>ureteral calculus (2) Bilateral Renal</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <i>Atrophic Testes Chronic Prostatitis Cystitis Cyst</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>June 6, 1963</i> to <i>Nov 15, 1967</i> , that (I) (we) last saw the deceased alive on <i>11/30, 1967</i> , and that death occurred at <i>1:15 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>W. Glen Speicher</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11-15-67</i>			
22c. PHYSICIAN'S NAME (Type) W. GLEN SPEICHER						22d. ADDRESS 135 E. MAIN ST. WESTMINSTER MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>11/18/67</i>		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEMORIAL				23d. LOCATION (City, town or county) (State) FINKSBURG CARROLL MD			
24. FUNERAL DIRECTOR <i>James G. Saffell</i>						ADDRESS WESTMINSTER, MD		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
						DATE NOV 17 1967					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15232

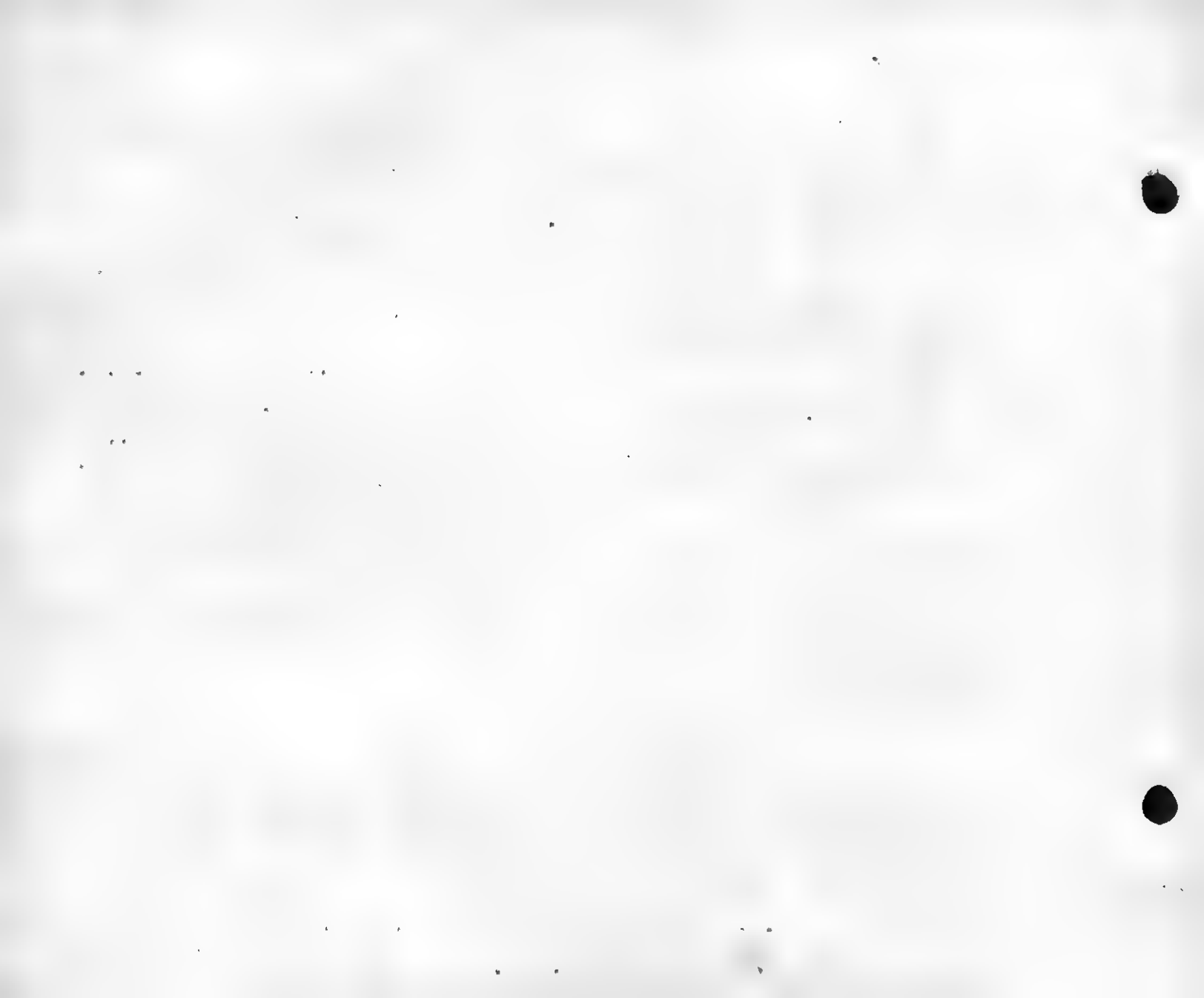
CERTIFICATE OF DEATH

15236

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN TB 22 hrs. 30 min d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS 319 Estate Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eric William Schultz		4. DATE OF DEATH Month Day Year November 30, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1967
9. AGE (in years last birthday) 22		10. IF UNDER 1 YEAR Months Day Hours Min 22 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Carroll Co., Maryland U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Carlos S. Schultz		14. MOTHER'S MAIDEN NAME Shirley L. Meisz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Carlos Schultz		18. ADDRESS 319 Estate Rd., Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory distress DUE TO (b) aspirin poisoning DUE TO (c) aspirin poisoning		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11:57 , 19 67 to 11:20 , 19 67 , that (I) (we) last saw the deceased alive on 11-27-67 , and that death occurred at 12:30 M. from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 11/30/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Reisterstown Meth. Cem. Reisterstown, Maryland	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR H. J. Eckhardt		25a. REC'D BY REGISTRAR Owings Mills, Md.	
25b. REGISTRAR'S SIGNATURE [Signature]		DATE DEC 4 1967	



15233

CERTIFICATE OF DEATH

15237

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b 8 hrs. 50 min.		2 USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admiss on) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL OR INST TUTION (If not in hospital, give street address) Carroll County General Hosp.		d. STREET ADDRESS 319 Estate Road	
3 NAME OF DECEASED (Type or print) First Middle Last Tony Louis Schultz		4. DATE OF DEATH Month Day Year November 29, 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/29/67
9 AGE (In years lost birthday) yrs. 8		10 IF UNDER 1 YEAR Months Days 8 50	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Carroll Co., Maryland U.S.A.		12 CIT ZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Carlos S. Schultz		14. MOTHER'S MAIDEN NAME Shirley L. Meisz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Carlos Schultz		Address 319 Estate Rd., Reisterstown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Respiratory Distress Syndrome DUE TO Premature Twin Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/29 , 19 67 , to 11/29, 1967 , that (I) was last saw the deceased alive on 11/29, 1967 , and that death occurred at 11:30 M, from causes and on the date stated above.			
22a. SIGNATURE Charles J. Judge		22b. DATE SIGNED 11/29/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMAT ON, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY Reisterstown Meth. Cem. Reisterstown, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR H. F. Eckhardt		ADDRESS Owings Mills, Md.	
25a. REC'D BY REGISTRAR DEC 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



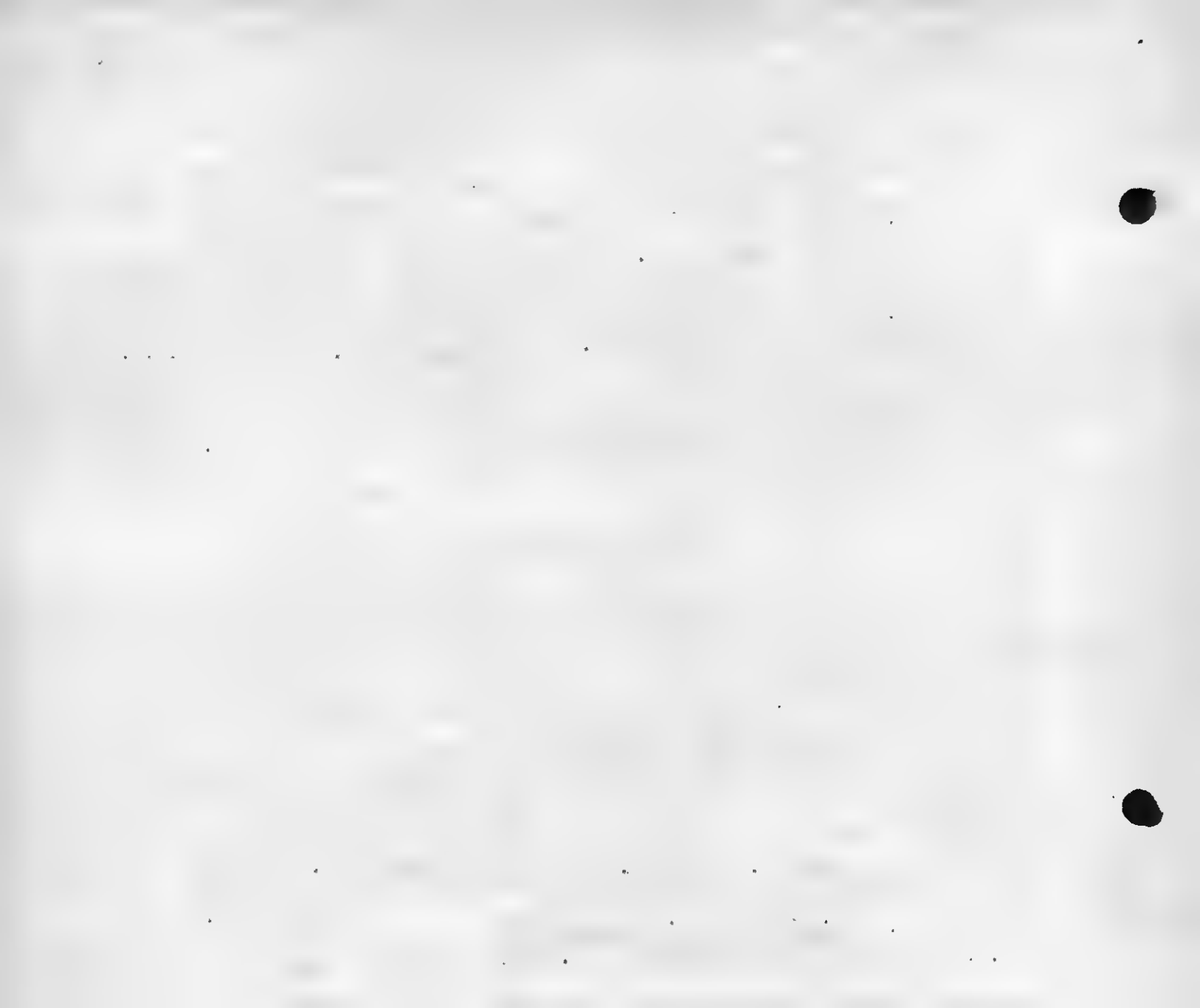
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15234
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
15238

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) New Windsor d. STREET ADDRESS Box 106 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arlena Middle M. Last Shaw		4. DATE OF DEATH Month 11 Day 21 Year 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23-1920	
9. AGE (In years last birthday) 47 yrs		10. IF UNDER 1 YEAR Months 11 Days 21	
11. IF UNDER 24 HRS Hours 4 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler		10b. KIND OF BUSINESS OR INDUSTRY Electric Co.	
11. BIRTHPLACE (County & State or foreign country) Wayneville-W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur W. Green		14. MOTHER'S MAIDEN NAME Glenna White	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-01-2187	
17. INFORMANT Walter E. Green-		Address New Windsor-Md. 21776- Box 106	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 351X Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)		INTERVAL BETWEEN ONSET AND DEATH 4 HOURS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/20, 1967 , to 11/21, 1967 , that (I) (we) last saw the deceased alive on 11/21, 1967 , and that death occurred at 2A.M. from the causes and on the date stated above.			
22a. SIGNATURE Vincent J. Fiocco Jr. M.D.		22b. DATE SIGNED 11/21/67	
22c. PHYSICIAN'S NAME (Type) Vincent J. Fiocco-Jr.		22d. ADDRESS Westminster, Md. 21157	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 24-1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 24 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>4</div> <div>1</div> <div>15235</div> <div>15239</div>											
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <u>Harroll</u>						a. STATE <u>Maryland</u> b. COUNTY <u>Harroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Westminster</u>					
c. LENGTH OF STAY IN 1b <u>8 days</u>						d. STREET ADDRESS <u>6. J. 5</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harroll</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last						4. DATE OF DEATH Month Day Year					
<u>John S. Harshey</u>						<u>Nov. 19, 1967</u>					
5. SEX <u>Male</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>Oct. 17, 1889</u>					
9. AGE (In years last birthday) <u>79</u> yrs.						10. IF UNDER 1 YEAR Months Days					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man-Retired</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Harroll Co., Md.</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John S. Harshey</u>						14. MOTHER'S MAIDEN NAME <u>Mary T. Harshey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>219-07-2165</u>					
17. INFORMANT <u>John S. Harshey</u>						Address <u></u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)											
DUE TO <u>arteriosclerosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u></u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<u>Arteriosclerotic Heart Disease</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> <u>1967</u> to <u>11/19</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> <u>1967</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above											
22a. SIGNATURE <u>John S. Harshey</u> M.D.											
22b. DATE SIGNED <u>11/19</u>											
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>											
22d. ADDRESS <u>Harroll St Westminster, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/19/67</u>											
23b. DATE THEREOF <u>11/19/67</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Harroll Co., Md.</u>											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Harshey</u> ADDRESS <u>Harroll Co., Md.</u>											
25a. REC'D BY REGISTRAR <u>NOV 21 1967</u>											
25b. REGISTRAR'S SIGNATURE <u>John S. Harshey</u>											



CERTIFICATE OF DEATH

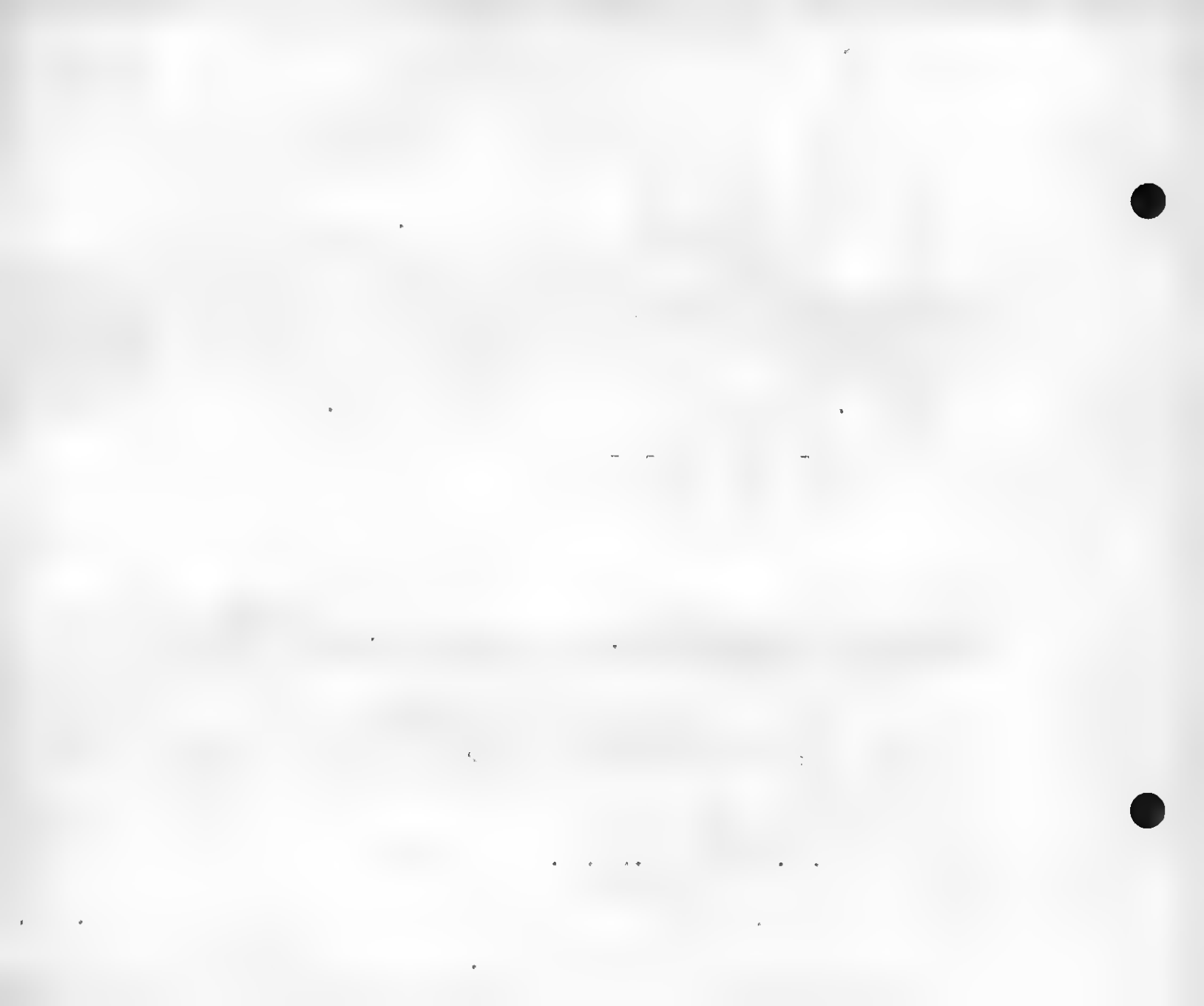
15240

15236

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 3) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SIKESVILLE		c. LENGTH OF STAY IN 1b 4yr 5 mo 13 da	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last WILLIAM CHARLES SNYDER		4 DATE OF DEATH Month Day Year 11 7 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04/07/90
9 AGE (In years lost birthday) 77 yrs		10. USUAL OCCUPATION (Give kind of work done during most of work, no life even if retired) Cigar maker	
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles A. Snyder		14. MOTHER'S MAIDEN NAME Sarah Eliz. Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1909-1912		16 SOCIAL SECURITY NO 003-09-1979	
17 INFORMANT Hospital Records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Chronic Arteriosclerotic Cardiovascular Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH minutes
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome assoc. with cerebral arteriosclerosis with neurotic reaction			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that as (this hospital) attended the deceased from 5/24/1963 , to 11/7/1967 , that we (we) last saw the deceased alive on 11/7 1967 , and that death occurred at 7:30 M, from causes and on the date stated above			
22a. SIGNATURE H. E. Connor, Jr.		22b. DATE SIGNED 9 Nov. 1967	
22c PHYSICIAN'S NAME (Type) H. E. Connor, Jr., M. D.		22d ADDRESS Springfield State Hospital	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Nov. 9, 1967	23c NAME OF CEMETERY OR CREMATORY Hampstead Cemetery	23d LOCATION (City or Town) (County) (State) Hampstead Carroll Co. Md.
24 FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.		25a REC'D BY REGISTRAR NOV 9 1967	25b REGISTRAR'S SIGNATURE O. Charles Judge



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #2b,c & d Film # 25237											
15237											
15941											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY Carroll						2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville						c. LENGTH OF STAY IN 1b Baltimore 21007					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Grand View Manor N. H.						d. STREET ADDRESS 6507 Windsor Mill Road					
3. NAME OF DECEASED (Type or print) First Middle Last Hulda Louise Sperber						4 DATE OF DEATH Month Day Year Nov 15 1967					
5 SEX F		6 COLOR OR RACE wh		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 10/1/96		9 AGE (in years last birthday) yrs 71		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Illinois			
13 FATHER'S NAME Oscar G. Sperber				14 MOTHER'S MAIDEN NAME Elise Tietze				12 CITIZEN OF WHAT COUNTRY? USA			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 220-48-8327				17 INFORMANT Miss Elsie Sperber Grand View Manor N. H. - Sykesville, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia - lobar DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ate - decomposing (c) Occurrence of pneumonia										INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-1-1967 to 11-15-1967, that (I) (we) last saw the deceased alive on 11-1-1967, and that death occurred at 4:15 P.M. from causes and on the date stated above.											
22a SIGNATURE James B. Saffell						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11-15-67			
22c. PHYSICIAN'S NAME (Type) James B. Saffell						22d. ADDRESS Baltimore, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/18/67		23c. NAME OF CEMETERY OR CREMATORY Western Cem.				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.						25a. REC'D BY REGISTRAR NOV 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15233

15242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 28yrs. 4mons.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 2514 Boarman Avenue	
3. NAME OF DECEASED (Type or print) MICHAEL A. SPINATO		4. DATE OF DEATH Month November Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1905
9. AGE (In years last birthday) 62 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	
11. BIRTHPLACE (County & State or foreign country) Baltimore City, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Spinato		14. MOTHER'S MAIDEN NAME Catharine Marinana	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Records, Springfield State Hosp., Sykes, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retroperitoneal malignant tumor (possible) DUE TO sarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) (c) Bronchopneumonia, right lung		INTERVAL BETWEEN ONSET AND DEATH Months Days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS with CNS syphilis, meningoencephalitic, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XX (this hospital) attended the deceased from 6-26- 1939, to 11-8 1967, that (I) (we) last saw the deceased alive on 11-8 1967, and that death occurred at 1:45pm , from causes and on the date stated above			
22a. SIGNATURE <i>Octavio A. Ruiz</i>		22b. DATE SIGNED Nov. 8, 1967	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22d. ADDRESS Springfield State Hospital, Sykes., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/11/67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.,	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #1		25a. REC'D BY REGISTRAR NOV 13 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RT #6 WESTMINSTER, MD.</u>	
c. LENGTH OF STAY IN 1b <u>11 DAYS</u>		d. STREET ADDRESS <u>WASHINGTON ROAD 224</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL COUNTY GEN. HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL ANNIE STEM</u>		4. DATE OF DEATH Month Day Year <u>NOV. 15 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1896</u> <u>AUG. 18, 1896</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTO., CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH TARBART</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE DIETZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>N</u>		16. SOCIAL SECURITY NO. <u>219-36-0072</u>	
17. INFORMANT <u>MRS. HERMAN MULLER, RT #6 WESTMINSTER, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/4</u> , 19 <u>67</u> , to <u>11/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>John S. Parshey</u>		22b. DATE SIGNED <u>11/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. PARSHEY MD</u>		22d. ADDRESS <u>8 Anchor St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>NOV. 19, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>TAYLORSVILLE METH. CH.</u>	23d. LOCATION (City or Town) (County) (State) <u>TAYLORSVILLE CARROLL, MD.</u>
24. FUNERAL DIRECTOR <u>James G. Saffell</u>		25a. REC'D BY REGISTRAR <u>NOV 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and have them filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15240

15244

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 5mo. 1day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 4905 Walther Avenue	
3 NAME OF DECEASED (Type or print) Martha Clare Strassner		4. DATE OF DEATH Month 11 Day 17 Year 19 67	
5 SEX female	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/92
9 AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Karwacki		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 217-1648925	
17. INFORMANT Springfield Hospital records, Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Cardiac failure DUE TO (c) Chronic brain syndrome associated with cerebral arteriosclerosis with behavioral reaction.			
INTERVAL BETWEEN ONSET AND DEATH days			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis with behavioral reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/16/ 19 67 to 11/17/ 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/17/ 19 67 , and that death occurred at 9:15 a.m. from causes and on the date stated above.			
22a. SIGNATURE Edmee J. Reeves		22b. DATE SIGNED 11/17/67	
22c. PHYSICIAN'S NAME (Type) Edmee J. Reeves, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 20, 1967	
23c. NAME OF CEMETERY OR CREMATORY Scard Heart Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Lilly & Zeiler Inc. F. H. 1901 Eastern Avenue		25a. REC'D BY REGISTRAR NOV 21 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

VR A15 (4)
25M 1/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

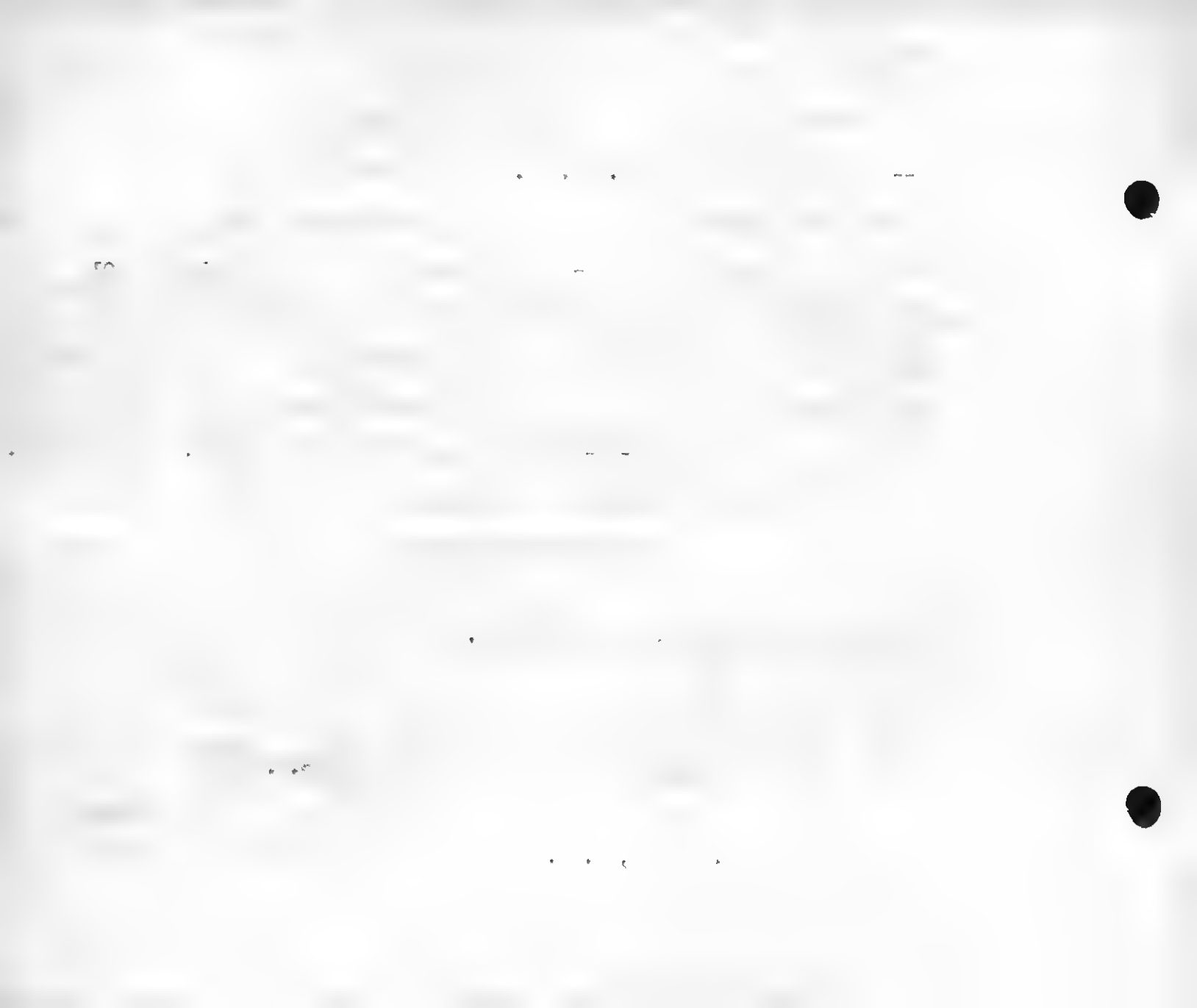
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst tut on Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c LENGTH OF STAY IN 'b 8y. 7m. 5d.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d STREET ADDRESS 1240 Cedarcroft Road	
3 NAME OF DECEASED (Type or print) First Rose Middle - Last Sugarman		4. DATE OF DEATH Month 11 Day 01 Year 1967	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/6/00
9 AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 11 Days 01	IF UNDER 24 HRS Hours 01 Mins. 00
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Isaac Sugarman	
14. MOTHER'S MAIDEN NAME Rachel Sulsky		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO 220-54-6015		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of the lungs DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Terminal bronchopneumonia DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 years days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Schizophrenic reaction, catatonic type.			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from 3/26/ 19 59 to 11/01/ 19 67 , that (he) (we) last saw the deceased alive on 11/01/ 1967, and that death occurred at 6:35 a.m. from causes and on the date stated above.	
22a. SIGNATURE Renato R. Espina M.D.		22b. DATE SIGNED 11/01/67	
22c. PHYSICIAN'S NAME (Type) Renato R. Espina, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF 11/2/1967	23c. NAME OF CEMETERY OR CREMATORY Anne Arundel City Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc.		25a. REC'D BY REGISTRAR NOV 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN 1b 40 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 MILTON AVE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER d. STREET ADDRESS 15 MILTON AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA LITTLE SULLIVAN First Middle Last		4. DATE OF DEATH NOVEMBER 9, 1967 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 5, 1928 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) LITTLESTOWN, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RUFUS LITTLE		14. MOTHER'S MAIDEN NAME ELIZABETH C. MASENHIMER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-44-9475	
17. INFORMANT MR. GEORGE A. SULLIVAN, Laneside Address 1367 W. Hollins (Dorsey)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 YEAR.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from NOV 6, 1967 to NOV 9, 1967 , that (I) (we) last saw the deceased alive on NOV 9, 1967 , and that death occurred at 10:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Daniel I Welliver		22b. DATE SIGNED 11-9-67	
22c. PHYSICIAN'S NAME (Type) DANIEL I WELLIVER MD		22d. ADDRESS 19 RIDGE RD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/13/67	23c. NAME OF CEMETERY OR CREMATORY TRIDERS CEMETERY	23d. LOCATION (City, town or county) (State) RURAL, WESTMINSTER MD
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.		25a. REC'D BY REGISTRAR 13 1967	
		25b. REGISTRAR'S SIGNATURE Richard Judge	



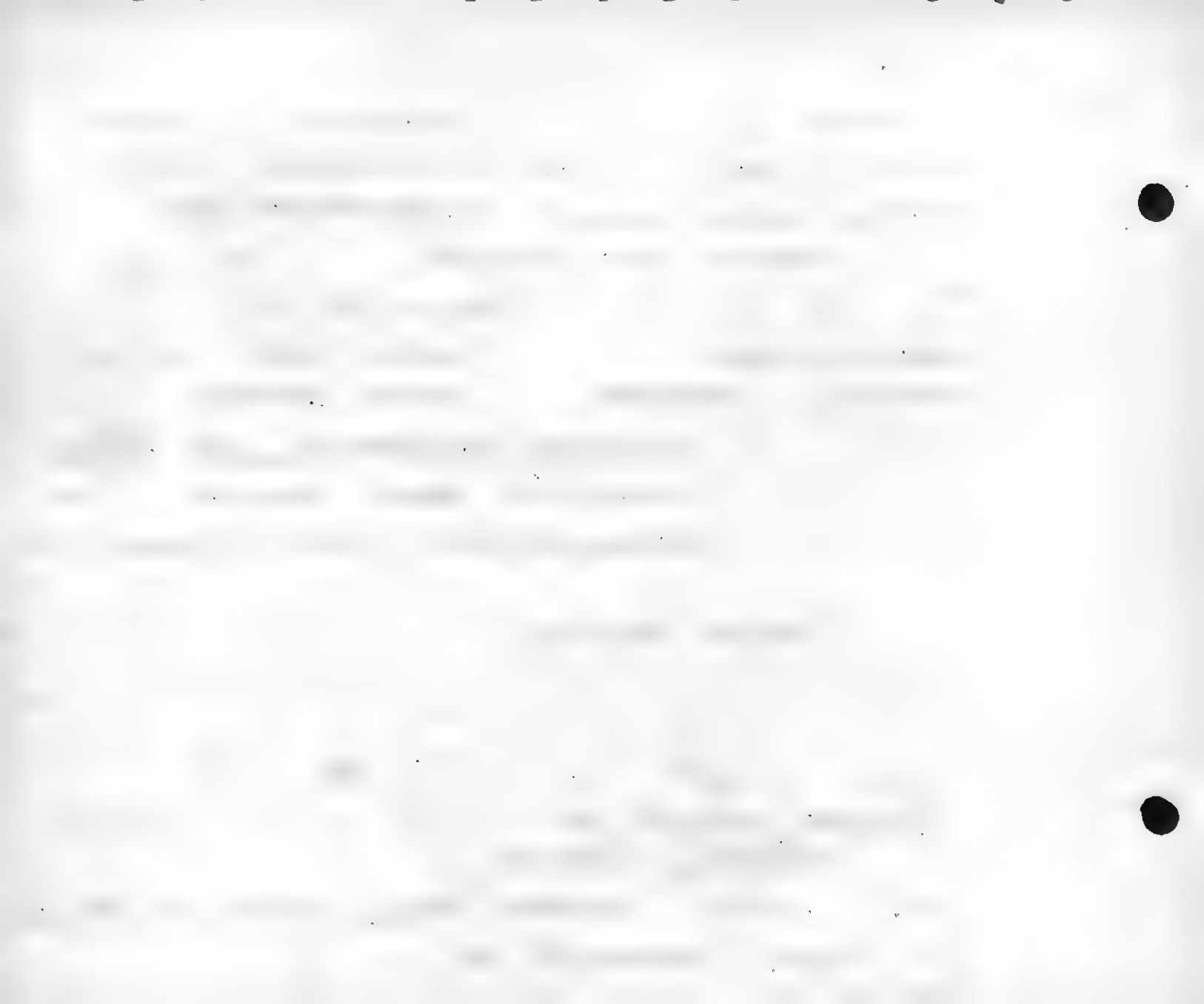
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
243
CERTIFICATE OF DEATH

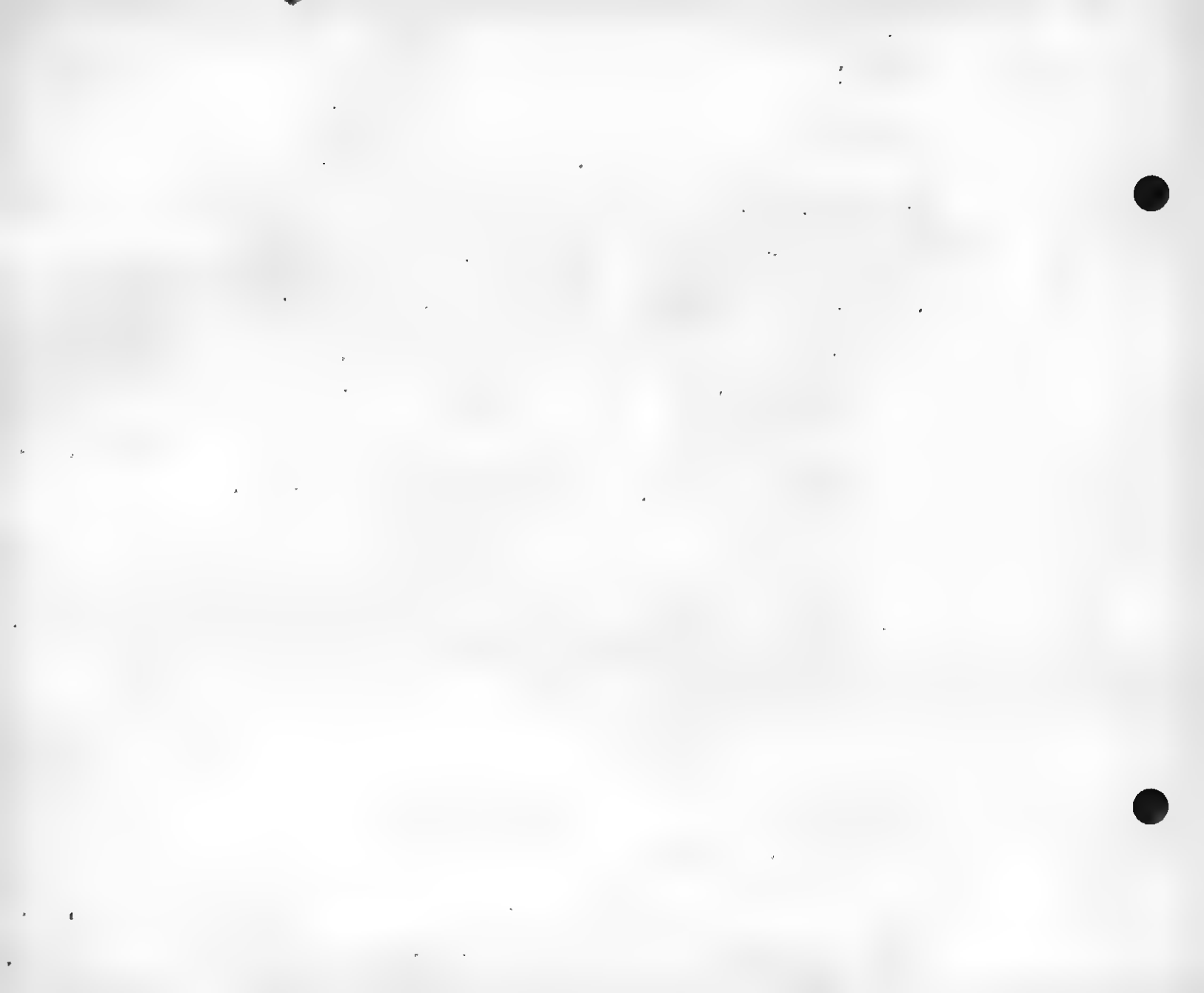
1. PLACE OF DEATH a. COUNTY CARROLL CO b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN 1b 6 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CARROLL CO. GEN. HOSPT.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER RT#4 d. STREET ADDRESS OLD BARKHESTER ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CARRIE MAY SULLIVAN		4. DATE OF DEATH Month Day Year 11 2 19 67	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1906
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK IN STORE		9b. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK IN STORE		10b. KIND OF BUSINESS OR INDUSTRY CARROLL CO. MD.	
11. BIRTHPLACE (County & State, or foreign country) CARROLL CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME IRVIN E. STEGNER		14. MOTHER'S MAIDEN NAME MINNIE MARKLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-20-8409	
17. INFORMANT MR. CLARK A. SULLIVAN		Address SAME ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE YEARS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH 2 MOS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/22, 1967 to 11/2, 1967 , that (I) (we) last saw the deceased alive on 11/2, 1967 , and that death occurred at 7:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Vincent J. Fiocco Jr.		22b. DATE SIGNED 11/2/67	
22c. PHYSICIAN'S NAME (Type) VINCENT J. FIOCCO, JR.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/5/67	
23c. NAME OF CEMETERY OR CREMATORY ZEISTERS CEMETERY WESTMINSTER RD#4 MD		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.		25a. REC'D BY REGISTRAR NOV 7 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Liberty, Md.</u>			c. LENGTH OF STAY IN 1b <u>4 mo.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg,</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brookfield Manor Nursing Home</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Jeanette</u> Last <u>Taylor</u>			4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>1967</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 21, 1883</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John K. Taylor</u>					14. MOTHER'S MAIDEN NAME <u>Theresa Click</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-18-2306 J</u>		17. INFORMANT <u>Joan Humerick, Emmitsburg, W. Main St., Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED ATHEROSCLEROSIS</u> 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerotic heart disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July 25, 1967</u> to <u>Nov. 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 13, 1967</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>J. H. Caricofe</u>					22b. DATE SIGNED <u>11/14/67</u>		22c. PHYSICIAN'S NAME (Type) <u>J. H. CARICOFE</u>		
22d. ADDRESS <u>Union Bridge Md 21791</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Nov. 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony's Shrine</u>		23d. LOCATION (City, town or county) (State) <u>Emmitsburg, Frederick Co. Md.</u>		
24. FUNERAL DIRECTOR <u>Clarence E. Wilson</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>				
25b. REGISTRAR'S SIGNATURE <u>Clarence E. Wilson</u>					DATE <u>NOV 16 1967</u>				



CERTIFICATE OF DEATH

15249

1 PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>Finksburg</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pullen Nursing Home</i>		d. STREET ADDRESS <i>Old Westminster Rd.</i>	
3 NAME OF DECEASED (Type or print) <i>John F. Thomas</i>		4 DATE OF DEATH Month <i>Nov</i> , Day <i>14</i> , Year <i>1967</i>	
5 SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Jan. 9, 1882</i>
9 AGE (In years last birthday) <i>85</i> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Carpenter</i>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
12 CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>William S. Thomas</i>	
14 MOTHER'S MAIDEN NAME <i>Julia A. North</i>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO <i>218-14-4227</i>		17. INFORMANT <i>Mrs. Ruby L. Myers</i> Address <i>Finksburg, Md.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO (b) <i>Chronic Disease</i> DUE TO (c) <i>decompensation</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <i>1-1-1963</i> to <i>11-14-1967</i> , that (1) (we) last saw the deceased alive on <i>11-8-1967</i> , and that death occurred at <i>4 P.M.</i> from causes and on the date stated above.			
22a SIGNATURE <i>James B. Syffel M.D.</i>		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>Finksburg, Md.</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Nov. 17, 67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Finksburg Methodist</i>	23d. LOCATION (City or Town) (County) (State) <i>Finksburg, Md.</i>
24. FUNERAL DIRECTOR <i>George A. Nusbaum</i> Address <i>Finksburg, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 20 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
REAL IDENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15245

15250

1 PLACE OF DEATH a COUNTY <u>CARROLL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>CARROLL</u>	
b CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>WESTMINSTER</u>		c LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GEN. HOSPITAL</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>IRVING WESLEY VAN FOSSEN</u>		4 DATE OF DEATH Month <u>NOVEMBER</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>SEPT 3, 1912</u>
9 AGE (In years last birthday) <u>55</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SANITOR AND WATCHMAN</u>		10b KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO. MD</u>	
11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>DUDLEY K. VAN FOSSEN</u>		14 MOTHER'S MAIDEN NAME <u>ADA KING VAN FOSSEN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u>		16 SOCIAL SECURITY NO <u>218-09-6894</u>	
17 INFORMANT <u>MRS. BESSIE F. VAN FOSSEN</u>		Address <u>SAME</u>	
18 CAUSE OF DEATH (Enter only one cause per PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis (acute)</u> DUE TO <u> </u> (b) <u> </u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u> </u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u> </u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Glenn Speicher</u>		22. DATE SIGNED <u>11-2-67</u>	
EXAMINER'S NAME (Type) <u>W. Glenn Speicher</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address <u>1358 Main Westminister, Carroll</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>11/4/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEMETERY</u>	23d LOCATION City <u>SILVER RUN</u> (County) <u>CARROLL</u> (State) <u>MD</u>
24 FUNERAL DIRECTOR <u>J. E. Myers, Jr., Westminister, Md.</u>		25a REC'D BY REGISTRAR <u> </u> 25b REGISTRAR'S SIGNATURE <u>MD</u>	
DATE <u>NOV 7 1967</u>		J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Carroll County MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 16 11 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS unknown	
3 NAME OF DECEASED (Type or print) Agnes Rosalia Van Tuyl		4 DATE OF DEATH Month November Day 9 Year 1967	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-84
9. AGE (In years last birthday) 83 yrs		10. F UNDER 1 YEAR Months Days 11. F UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY HOUSE	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Kenny		14. MOTHER'S MAIDEN NAME Margaret Reidy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-54-6030J1	
17. INFORMANT Medical Record		Address Springfield Hospital, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Anemia DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Hours Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Paranoid type.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3-31 , 19 56 , to 11-9 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11-9 , 19 67 , and that death occurred at 1:34pm , from causes and on the date stated above			
22a. SIGNATURE Renan N. Espina, M.D.		22b. DATE SIGNED 11-9-67	
22c. PHYSICIAN'S NAME (Type) Renan N. Espina, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Md. 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-13-67	23c. NAME OF CEMETERY OR CREMATORY Rockledge	23d. LOCATION (City or town) (County) (State) Rockledge, N. Y.
24. FUNERAL DIRECTOR Harry W. Haight		25a. REC'D. BY REGISTRAR NOV 14 1967	
ADDRESS Sykesville, Md.		25b. REGISTRAR'S SIGNATURE James Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

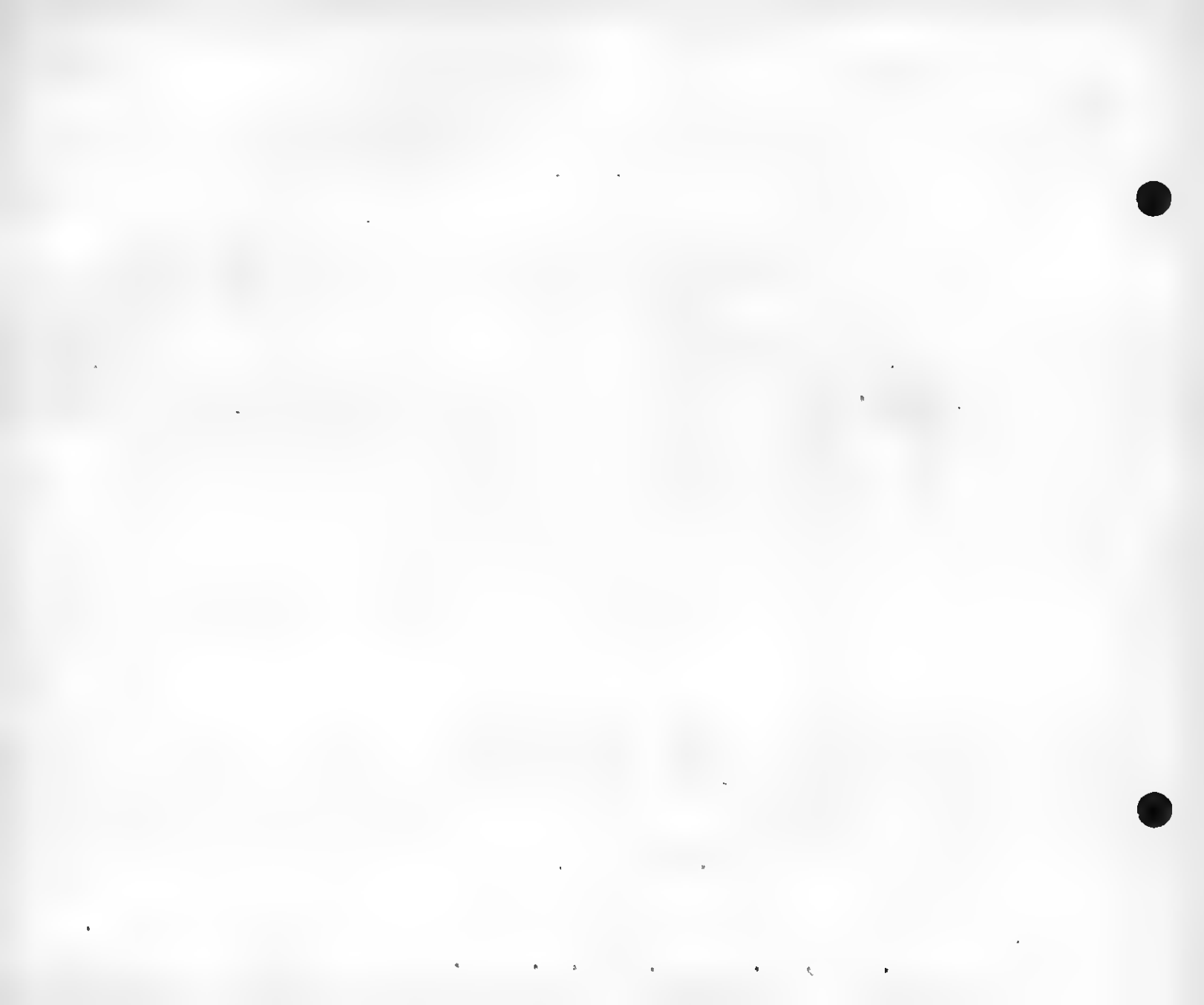
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Baltimore City ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c LENGTH OF STAY IN 1b 1mo. 4dys.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d STREET ADDRESS 525 St. Francis Road	
3. NAME OF DECEASED (Type or print) First JAMES Middle RONALD Last WALKER		4. DATE OF DEATH Month NOVEMBER Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-1890
9. AGE (In years last birthday) 76 yrs		10. FUND 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plantation manager (retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry M. Walker		14. MOTHER'S MAIDEN NAME Alice (last name unknown) McMahon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-2735	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-29-67 to 11-3-67 , 19 67 , that (I) (we) last saw the deceased alive on 11-3-67 , 19 67 , and that death occurred at 1:15 PM , from causes and on the date stated above			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 11-3-67	ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/6/67	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balto. St. Balto.		25a. REC'D BY REGISTRAR NOV 7 1967	25b. REGISTRAR'S SIGNATURE James J. [Signature]



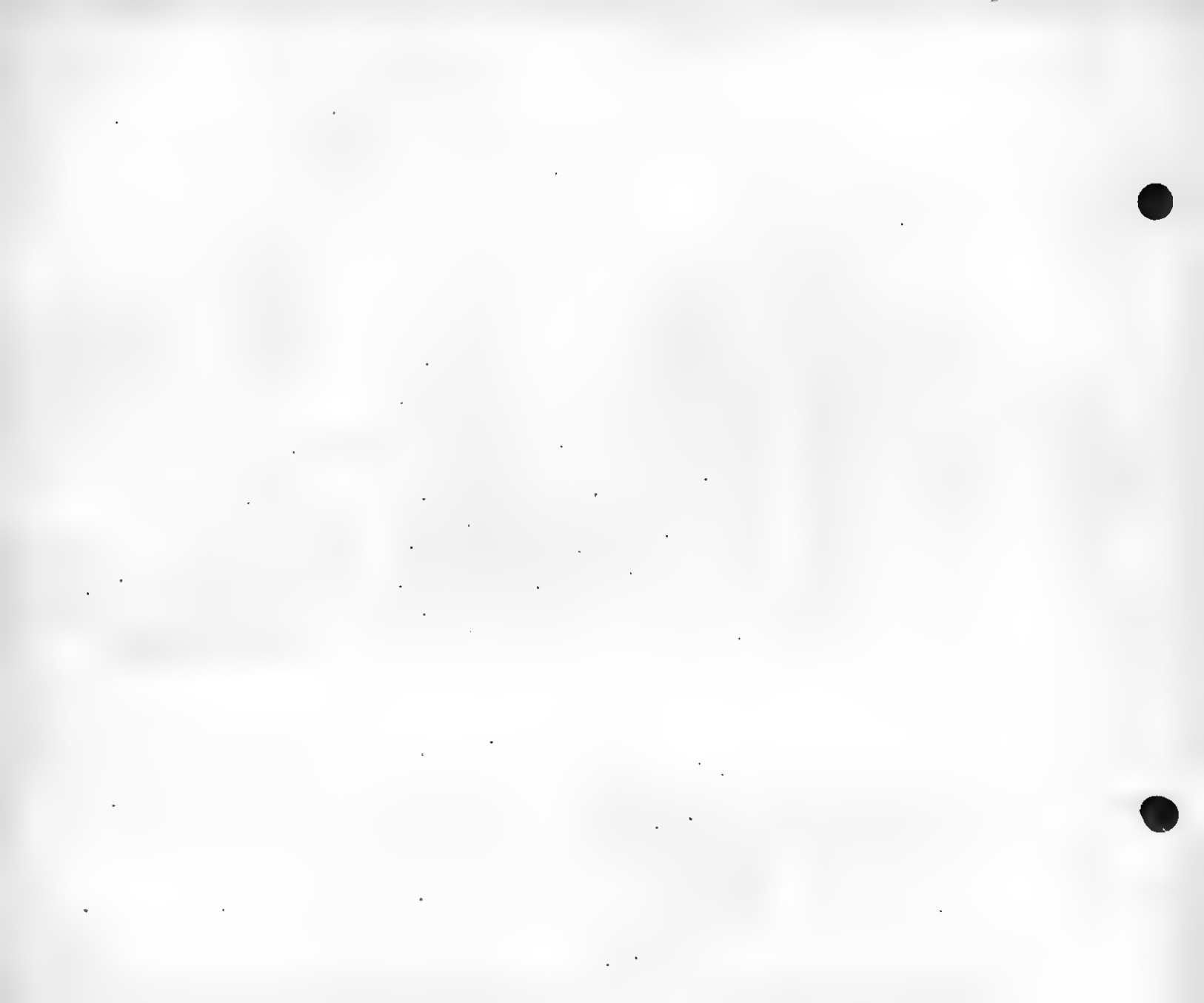
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RT #7</u>				c. LENGTH OF STAY IN 1b <u>84 YRS.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RT #7</u>				d. STREET ADDRESS <u>HALTER ROAD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HALTER ROAD</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>IRVIN</u> Middle <u>EDGAR</u> Last <u>WANTZ</u>						4. DATE OF DEATH Month <u>NOV</u> Day <u>10</u> Year <u>1967</u>					
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 24 1882</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT WANTZ</u>						14. MOTHER'S MAIDEN NAME <u>CLARA FROCK</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>270-34-7219</u>		17. INFORMANT <u>MRS. CORA WAREHIME WANTZ</u>				Address <u>SAME ADDRESS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease (chronic)</u> <u>422</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis genl</u> DUE TO (c) <u>Slight stroke ulcer blood</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic Hypertrophy</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4-5</u> <u>5 yrs</u> <u>3 1/2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-26-63</u> to <u>11-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-10</u> , 19 <u>67</u> , and that death occurred at <u>10:45 PM</u> and the causes and on the date stated above.											
22a. SIGNATURE <u>William Speicher M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS <u>—</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>11/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT VALLEY CEM. WESTMINSTER RT #7 MD.</u>				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>J. E. Meyer, Jr., Westminster, MD.</u>						25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>NOV 13 1967</u>											



CERTIFICATE OF DEATH

15254

1 PLACE OF DEATH a COUNTY <u>CARROLL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if resident on Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>CARROLL</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c LENGTH OF STAY IN 1b <u>8 YEARS</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROUTE 5</u>		d STREET ADDRESS <u>ROUTE 5</u>	
3 NAME OF DECEASED (Type or print) <u>EARL RELET WARNER</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>22 OCT. 1877</u>
9 AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER - RETIRED - OWNER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>URIAH WARNER</u>		14 MOTHER'S MAIDEN NAME <u>JULIA ANN COPPERSMITH</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>220-54-5051</u>	
17 INFORMANT <u>MRS. CHARAK. WARNER</u>		Address <u>RS MD WESTMINSTER</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic CVD</u> DUE TO (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>1 AM</u> , 19 <u>67</u> , that (I) was lost saw the deceased alive on <u>11/30/67</u> , and that death occurred at <u>1 A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>M.E. Robertson</u>		22b. DATE SIGNED <u>11/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. ROBERTSON</u>		22d. ADDRESS <u>NEW WINDSOR, MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>3 DEC. 1967</u>	<u>ST. JAMES CEM.</u>	<u>DENNINGS, MD</u>
24. FUNERAL DIRECTOR <u>DR. HUBERTSON</u>		25a REC'D BY REGISTRAR <u>DEC 4 1967</u>	
ADDRESS <u>NEW WINDSOR MD</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland. b. COUNTY Carroll	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md.		c LENGTH OF STAY IN Ib 2yrs. 1mon. 2days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d STREET ADDRESS 403 E23St.	
3 NAME OF DECEASED (Type or print) First Ernest. Middle NM Last Weems.		4. DATE OF DEATH Month 11-25-67 Day 19 Year 19	
5 SEX Male	6 COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-18-82
9 AGE (in years last birthday) 85 yrs		10. IF UNDER 1 YEAR Months 11 Days 25 Hours 00 Min 00	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman-Retired		10b. KIND OF BUSINESS OR AND RETIRED	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George, Weems.		14. MOTHER'S MAIDEN NAME Matilda, Evans.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-12-4499	
17 INFORMANT Hospital Records -		Address Sykesville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 150x IMMEDIATE CAUSE (a) Cancer, esophagus of unknown duration DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome 20 to 30 years duration			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-27- , 19 65 , to 11-25- , 19 67 , that (I) (we) last saw the deceased alive on 11-25- , 19 67 , and that death occurred at 3:30 A M, from causes and on the date stated above.			
22a SIGNATURE G. G. Sagisi		22b DATE SIGNED 11-25-67	
22c PHYSICIAN'S NAME (Type) G. G. Sagisi, M.D.		22d ADDRESS Springfield State Hospital Sykesville, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) burial	23b DATE THEREOF 12/2/67	23c. NAME OF CEMETERY OR CREMATORY Cears Bethel Cemetery	23d LOCATION (City or Town) (County) (State) Burkittsville, Fred., MD
24 FUNERAL DIRECTOR Shadhill Co. Middletown, Md.		25a. REC'D BY REGISTRAR DEC 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15252		Item #1d Film #G390 11/13/67 PH		15256	
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>YORK</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>4 mon</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>YORK SPRY, PA. 153</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3 Hersh Avenue</u>			d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HORACE</u> Middle <u>Melville</u> Last <u>Winholt</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>1</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-1895</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - NAVAL ORD.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't - MAINT.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTO. County - Md.</u>	
13. FATHER'S NAME <u>MOSES - WINEHOLT</u>			14. MOTHER'S MAIDEN NAME <u>Smith</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>219-07-8220A</u>		17. INFORMANT <u>Calvin (son)</u> Address <u>HANOVER, R.D. #3, PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO (b) <u>Venous STASIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Debat CHF 2° Myocardial Infarction 6 mi</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 mi</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11-45 AM</u> p.m. <u>4:45</u> 19 <u>67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 15, 1967</u> , to <u>Nov 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 30, 1967</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Dean H. Buff</u>			22b. DATE SIGNED <u>11-1-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dean H. Buff</u>			22d. ADDRESS <u>19 Ridge Rd, Westminster, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUSANNEHANNA MEM. GARDENS</u>	23d. LOCATION (City, town or county) (State) <u>YORK TWP. YORK PA.</u>		
24. FUNERAL DIRECTOR <u>J. S. Myers - J. Westminister</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>Nov 3 1967</u>					



CERTIFICATE OF DEATH

15253

15257

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 64 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1 PARK AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PHOEBE HELEN WOODWARD		4. DATE OF DEATH Month Day Year NOV. 4 19 67	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 27, 1881
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) FREDERICK CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM C. NEIDIG		14. MOTHER'S MAIDEN NAME EMMA BARBARA NINEBRENNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Atherosclerotic Heart Disease DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Intestinal obstruction			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1963 , to Nov 4, 1967 , that (I) (we) last saw the deceased alive on Nov 3, 1967 , and that death occurred at 3 A.M. from causes and on the date stated above.			
22a. SIGNATURE John S. Harshey		22b. DATE SIGNED 11/4/67	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS 8400 St. Westminster Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/7/67	23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH	23d. LOCATION (City or Town) (County) (State) RURAL WESTMINSTER MD
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.		25a. REC'D BY REGISTRAR DATE NOV 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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10337

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WILLIAM D. REID

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